CharterLIFE™
Believe Build Benefit

2024 Renewal & Open Enrollment

CharterLIFE™
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Index

Dear Charter School Leader:

Hello! We hope this message finds you well and that you're having a successful school year. We appreciate your patience during this year's renewal process. The process has been challenging, as we have expressed in recent communications, but we feel very good about the work that was done in order to furnish our members with a favorable renewal. Enclosed, please find the complete details of the benefits/programs for the 2024 renewal.

This year has been exceptionally difficult with the massive number of claims, carrier guideline changes, and health insurance increases industry wide. Kaiser Permanente, throughout California, leveled nearly a 20-25% renewal increase to all their current public sector members – CharterLIFE included. These reasons and extensive carrier negotiations have presented some timeline challenges again this year and we appreciate your patience. It was quite a heavy-lift to bring the renewal to a palatable increase and remain within our "standard" trend. Despite the many obstacles, we're pleased with the outcome and believe you will be as well.

Our efforts and the final results are a reminder of the dedicated work we do on behalf of you, and all our members! As we have stated time and time again, CharterLIFE negotiates FOR you – the members! CharterLIFE is NOT an insurance broker and does not earn commission, we work for the members and we are here as a trusted resource for your school board and staff.

CharterLIFE is aware of the very tight timelines in which you have to present these benefits out to your staff. We also understand that you and your staff may have questions and may need additional support during the open enrollment process. Please know, that we have dedicated additional staff and resources to ensure you and your school's needs are met and hopefully exceeded! Please make note of the important email addresses below; for a more efficient administrative experience email TEAMS@CharterLIFE.org and for staff inquiries email HELP@CharterLIFE.org.

Please contact your Account Manager to discuss your renewal and. rates, and the Open Enrollment timeline We need to understand how we can best support you in communicating with your staff, schedule any benefit presentations, and to address any other questions or concerns you may have. Your open enrollment will be seamless and familiar as possible, especially with having no benefit changes this year. Your dedicated support team will provide you with open enrollment assistance, customized employee Benefit Information Guides (C-BIGS) and any carrier resources you may need.

Please take a moment to read the very important renewal information enclosed in this benefit package. If you have any questions or concerns; please contact your account manager, or a benefits specialist at our NEW EMAIL address TEAMS@CharterLIFE.org or call 1-866-755-6651 select (option 1).

Sincerely,

The CharterLIFE Team

As the Trust Administrator for CharterLIFE, we would like to take this opportunity to notify you that the 2024 health benefits renewal and Open Enrollment (OE) period is here!

The Open Enrollment period will begin *Tuesday, May 28, 2024 and continue through Friday, June 14, 2024* for coverage to be effective July 1, 2024 through June 30, 2025. If an extension to your Open Enrolment period is needed, please indicate this on your OE Questionnaire & Checklist.

Enclosed you will find your Benefit Package with the following important documents for your review and completion.

- Index
- Welcome Letter
- Contacts
- OE Questionnaire & Checklist (**ACTION NEEDED)**
- Trust Documents: (**ACTION NEEDED)**
  - ✓ Participation Adoption Agreement
  - ✓ Addendum to Waiver
  - ✓ Attachment A

  *(Complete and return ALL "ACTION NEEDED" items via email Enrollment@CharterLIFE.org or via fax at **916.467.1404.***
- Rate Sheets and Benefit Comparison
- Carrier Plan Summaries
  - ✓ Anthem Blue Cross
  - ✓ Kaiser
  - ✓ Delta
  - ✓ VSP
  - ✓ Unum

We are very excited to announce some of the benefit changes below for the 2024 plan year!

Anthem Blue Cross: **No Benefit Changes!** *Please note other ACA mandates and company (carrier) changes, refer to summaries for complete list of changes*.

Optum (Pharmacy Benefit Manager): **No Benefit Changes!**

Kaiser Permanente: **No Benefit Changes!** *Please note other ACA mandates and company (carrier) changes, refer to summaries for complete list of changes*.

Delta Dental of CA: **No Benefit Changes!** *Please note other ACA mandates and company (carrier) changes, refer to summaries for complete list of changes.*

VSP: **No Benefit Changes!** *Please note other ACA mandates and company (carrier) changes, refer to summaries for complete list of changes.*

UNUM BASIC LIFE/AD&D/EAP & VOLUNTARY LIFE/AD&D: **No Benefit Change!** *Please note other ACA mandates and company (carrier) changes, refer to summaries for complete list of changes.*

If you would like to schedule a My Health Benefits Online System Training, please let us know. We encourage you to schedule a training if you're a new staff member.

**For a complete benefits summary for each carrier, please refer to your open enrollment kit provided by your benefits specialist.*

The Next Steps Are:

- ✓ Complete and submit your questionnaire and Trust documents on or before the deadline.
- ✓ A benefits specialist will contact you to schedule your virtual OE meeting date and time.
- ✓ Accept 2024 Trust renewal. *(**Must** receive all executed Trust Documents: Participation Adoption Agreement, Addendum to Waiver, and Attachment A)*
- ✓ A benefits specialist will confirm your requested virtual OE date and time. *(Optional, but recommended)*
- ✓ Schedule My Health Benefits (*formerly Vbas)* Webinar Training *(Optional)*
- ✓ SUBMIT ENROLLMENT

We appreciate your patience and continued partnership and look forward to another successful year! If you have any questions, please do not hesitate to call us at **1-866-755-6651 (Select Option 1)** or email **CharterLIFE@brmsonline.com.**

Sincerely,

Benefit & Risk Management Services On Behalf of CharterLIFE
80 Iron Point Circle, Suite 200 | Folsom, CA 95630
P 866.755.6651 | F 916.467.1404 | CharterLIFE@brmsonline.com

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2024 Renewal Summary

Submit Renewal Acceptance/Enrollment To: BRMS

Secure Email: CharterLIFE@brmsonline.com

Phone: 866.755.6651 (option 2)

Fax: 916.467.1404

Customer ID: Vbas #2089

2024 Excel Academy Charter School Renewal Comparison

CharterLIFE™ Renewal Rates 2024 q3 | **SC**

Tier	BC EPO High	BC EPO Low	BC EPO Base	BC PPO High	BC PPO Low	BC PPO Base	Kaiser HMO High	Kaiser HMO Low	Kaiser HMO HDP $1500	Kaiser HMO HRA $3000	Dental PPO 2000	Dental PPO 1000	DeltaCare HMO	VSP VISION	Life 25,000	Life 50,000
Employee Only	$798.81	$730.03	$676.30	$1,319.19	$1,213.92	$944.42	$917.74	$842.91	$787.15	$570.42	$58.69	$51.18	$14.81	$9.47		
Employee+1											$114.12	$95.30	$28.20	$18.72	$2.68	$5.37
EE + Sp	$1,757.39	$1,606.08	$1,487.86	$2,902.24	$2,670.66	$2,077.70	$2,019.03	$1,854.41	$1,731.73	$1,254.92						
EE + Chld/ren	$1,437.86	$1,314.06	$1,217.37	$2,374.56	$2,185.08	$1,699.95	$1,651.93	$1,517.23	$1,416.86	$1,026.74					-	117
Family	$2,475.89	$2,263.11	$2,096.55	$4,089.52	$3,763.20	$2,927.69	$2,845.00	$2,613.02	$2,440.16	$1,768.29	$188.50	$156.62	$45.51	$30.66		
Total EE's	-	27	2	14	5	1	6	18	2	-	18	36	20	64		

Tier	BC EPO High	BC EPO Low	BC EPO Base	BC PPO High	BC PPO Low	BC PPO Base	Kaiser HMO High	Kaiser HMO Low	Kaiser HMO HDP $1500	Kaiser HMO HRA $3000	Dental PPO 2000	Dental PPO 1000	DeltaCare HMO	VSP VISION	Life 25,000	Life 50,000
Employee Only		2	0	12	3	1	1	4	0		6	4	2	15		
Employee+1											6	7	6	17		
EE + Sp		0	1	0	1	0	0	2	0							117
EE + Chld/ren		21	1	0	1	0	3	1	1							
Family		4	0	2	0	0	2	11	1		6	25	12	32		
Total EE's		27	2	14	5	1	6	18	2		18	36	20	64		117
Monthly		$ 33,047.61	$ 2,346.02	$ 20,821.38	$ 7,369.22	$ 819.02	$ 9,658.60	$ 29,006.11	$ 3,492.34		$ 2,064.96	$ 4,564.20	$ 712.18	$ 1,441.41		$ 628.28
Monthly New		**$ 38,107.67**	**$ 2,705.22**	**$ 24,009.37**	**$ 8,497.50**	**$ 944.42**	**$ 11,563.52**	**$ 37,340.94**	**$ 3,857.02**		**$ 2,167.86**	**$ 4,787.32**	**$ 744.94**	**$ 1,441.41**	**$ -**	**$ 628.28**
Annual		$ 396,571.32	$ 28,152.24	$ 249,856.56	$ 88,430.64	$ 9,828.24	$ 115,903.20	$ 348,073.32	$ 41,908.08		$ 24,779.52	$ 54,770.40	$ 8,546.16	$ 17,296.92	$ -	$ 7,539.36
Annual New		**$ 457,292.00**	**$ 32,462.67**	**$ 288,112.46**	**$ 101,970.04**	**$ 11,332.98**	**$ 138,762.27**	**$ 448,091.30**	**$ 46,284.18**		**$ 26,014.32**	**$ 57,447.84**	**$ 8,939.28**	**$ 17,296.92**	**$ -**	**$ 7,539.34**
Change (+/-) %		**15.31%**	**15.31%**	**15.31%**	**15.31%**	**15.31%**	**19.72%**	**28.73%**	**10.44%**		**4.98%**	**4.89%**	**4.60%**	**0.00%**		**0.00%**

*some figures may be rounded up/down and/or pending final approval for this presentation, please refer to your bill for
** Cobra participants are not included in this representation of your renewal
Pending Final Action

Premium Summary		CURRENT	RENEWAL
Monthly Premium*		$115,971.33	$136,795.47
Annual Premium*		$1,391,655.96	**$1,641,545.61**
Monthly Increase*			**$20,824.14**
Annual Increase*			**$249,889.65**
Increase %			**17.96%**

CharterLIFE™

Administered by: Benefit & Risk Management Services, Inc. PO BOX 2080, Folsom, CA 95630
Secure Email: CharterLIFE@brmsonline.com **Phone:** 866.755.6651 (option 2) **Fax:** 916.467.1404

CharterLIFE™ - In Partnership with Dickerson Employee Benefits License# OF69768

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Contact Form and Contacts Sheet

CharterLIFE Contacts

CharterLIFE CONTACT INFORMATION			
Benefit	**Contact**	**Phone**	**E-Mail Address**
MyHealthBenefits Online	BRMS/TPA	866.755.6651 (option 1)	CharterLIFE@BRMSonline.com
Eligibility / COBRA / FSA	BRMS/TPA	866.755.6651 (option 1)	CharterLIFE@BRMSonline.com
Billing Questions	BRMS/TPA	866.755.6651 (option 2)	CharterLIFE@BRMSonline.com
Voluntary Benefits (Colonial)	BRMS/TPA	866.755.6651 (option 1)	CharterLIFE@BRMSonline.com
Account Manager/DEB	Dickerson	323.310.0834	teams@CharterLIFE.org
CharterLIFE Director	Damon Johnson	818.400.6171	Djohnson@CharterLIFE.org
CharterLIFE CEO	Misti Cole	916.500.1122	MCole@CharterLIFE.org
CharterLIFE Website	www.CharterLIFE.org	888.392.3928	info@CharterLIFE.org

CARRIER CONTACT INFORMATION			
Benefit:	**Provider:**	**Phone:**	**Website:**
Medical (EPO/PPO)	Anthem Blue Cross	800.227.3670	www.anthem.com/ca
Home Delivery Pharmacy	Optum Rx	844.568.2145	www.optumrx.com
Medical Kaiser HMO	Kaiser Permanente	800.464.4000	www.kaiserpermanente.org
Dental (HMO/PPO)	Delta Dental	800.422.4234 (HMO) 800.765.6003 (PPO)	www.deltadentalins.com
Vision	VSP Vision	800.877.7195	www.vsp.com
Life/AD&D/Supplemental Life	UNUM	800-421-0344	www.unum.com
Voluntary Benefits	Colonial	866.755.6551 (opt.1)	www.Coloniallife.com
Retiree Medical Benefits	Dickerson	323.310.0834	teams@CharterLIFE.org

School Contact Information Form

Charter School Name:	
Charter School CDE #:	
Physical Address:	
Physical City:	
Physical State & Zip Code:	

Contract Signee's Contact Information:

Date	Name	Title	Address	City	State	Zip Code	Phone #	Email Address

Primary Eligibility Contact Information:

Date	Name	Title	Address	City	State	Zip Code	Phone #	Email Address

Additional Primary Eligibility Contact Information:

Date	Name	Title	Address	City	State	Zip Code	Phone #	Email Address

Billing Contact Information:

Date	Name	Title	Address	City	State	Zip Code	Phone #	Email Address

Additional Billing Contact Information:

Date	Name	Title	Address	City	State	Zip Code	Phone #	Email Address

Outsource Billing Provider Contact Information: ***(if none, please skip this section)***

Outsource Billing Provider Name: (i.e. ExED, etc.)

Date	Name	Title	Address	City	State	Zip Code	Phone #	Email Address

CharterLIFE Benefits Specialist: ***(this section will be completed by the CharterLIFE benefits specialist)***	
Company Name:	
Account Manager's Name:	
Address, City, State & Zip:	
Contact Phone #:	
Email Address:	

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OE Questionnaire & Checklist

2024 Open Enrollment Questionnaire & Checklist

Charter School Legal Name: _____
(Print)

School Primary Eligibility Contact Name: _____
(Print)

Phone #: _____ Email: _____

Section 1: Open Enrollment Questionnaire

(Please complete the below questionnaire, completed required trust documents and send to Enrollment@CharterLIFE.org or fax to 916-467-1404 no later than May 28, 2024. Failure to meet the deadline may cause a delay to your charter school's open enrollment).

1. Benefit Fair Date Request (All Staff)

(Please enter three (3) options from May 28, 2024 through June 14, 2024, for a Trust benefit specialist and/or carrier(s) to conduct your virtual benefit enrollment fair. An email will be sent to confirm your virtual benefit fair and open enrollment date).

Virtual or onsite benefit fair can only be conducted after ALL Trust docs have been completed and submitted to BRMS.

Virtual benefit fair with online MHB* EE self-service enrollment can only be scheduled for a date 3 business days after the submission date of ALL Trust documents. Sorry, no exception.

	Date:	**Time:**
Option 1:	_____	_____
Option 2:	_____	_____
Option 3:	_____	_____

If you do not wish to have a virtual benefit fair with benefit specialist and/or carrier(s), please check this box. ☐

(Optional, but highly recommended. A benefits specialist will contact you to discuss the electronic enrollment process and coordination).

MyHealthBenefits (MHB) formerly known as Vbas

2. Answer the following questions regarding your contributions/benefit allowance for employees.

1. **Do you contribute 100% for your employees' and their dependent(s) healthcare* benefits that are offered through the CharterLIFE?**

☐ **Yes** (*If answer is yes, skip to Section2).*

☐ **No** *(If the answer is no, please indicate the percentage of healthcare benefits contributed for employees and their dependents).*

Medical: Employee _____% Dental: Employee _____% Vision: Employee _____%

Dependent_____% Dependent_____% Dependent_____%

☐ N/A** ☐ N/A** ☐ N/A**

2024 Open Enrollment Questionnaire & Checklist

2. Do you contribute an annual benefit allowance (e.g. dollar amount) for your employees' and/or their <u>dependent(s)</u> healthcare* benefits that are offered through the CharterLIFE?

☐ **Yes** *(If the answer is yes, please indicate the annual benefit allowance for each healthcare* plan offered for employees and their dependents).*

Medical: Employee $_____ Dependent $_____ ☐ N/A**

Dental: Employee $_____ Dependent $_____ ☐ N/A**

Vision: Employee $_____ Dependent $_____ ☐ N/A**

Healthcare benefits includes: medical, dental, and vision.
****Complete the above contributions/benefit allowance for only benefits offered through CharterLIFE.***

Note: We may contact you to obtain more information regarding your charter school's contributions/benefit allowance.

3. Are you interested in implementing a <u>new</u> BRMS administered Flexible Spending Account (FSA)?

☐ **Yes** ☐ **No** ☐ **Renew** *(If FSA has already been implemented last year.)*

If Yes, check the type of FSA plan(s) to be implemented.

1. **Medical Plan** ☐ **Maximum Annual Amount** *(up to $3,200)*: _____
2. **Dependent Care Plan** ☐ **Maximum Annual Amount** *(up to $5,000)*: _____

BRMS representative will follow up with your charter school to begin the implementation process.

4. Are you interested in implementing Voluntary Products? Check all that applies.

☐ **Colonial Group Accident**
☐ **Colonial Group Cancer**
☐ **Colonial Group Critical Care**
☐ **Colonial Group Medical Bridge**
☐ **Unum Voluntary Employee, Spouse and Child Life**
☐ **Unum Voluntary Employee, Spouse and Child AD&D**

BRMS representative will follow up with your charter school to begin the implementation process for any new voluntary product selections. .

5. Executed Required Trust Documents*:

- Participation Adoption Agreement (CharterLIFE_PAA)
- Addendum to Waiver (CharterLIFE_AA_Addendum)
- Attachment A (CharterLIFE_TRUST_Attachment_A)

☐
☐
☐

*Must be signed by the charter school's contract signee and returned by **Wednesday, May 22, 2024** to renew with the trust. Failure to receive these required trust documents may cause a delay to your charter school's electronic open enrollment access and renewal.*

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Trust Documents (Complete & Return)

PARTICIPATION ADOPTION AGREEMENT

This Adoption Agreement is made and entered into by and between _____ ("Participating Employer") and CharterLIFE™ ("Trust Fund").

The Participating Employer will contribute to the Trust Fund for: **(Check one)**

- ☐ All employees whose full time equivalency is equal to or greater than 50% (0.5 FTE), excluding employees who are covered by a collective bargaining agreement
- ☐ All employees whose full time equivalency is equal to or greater than 50% (0.5 FTE), including employees who are covered by a collective bargaining agreement
- ☐ If none of the above alternatives apply, please describe covered employment in the following classifications:

  _____
  _____
  _____
  _____

The Participating Employer acknowledges that full-time is that amount of time (months, weeks, days or hours) spent regularly in a position and is considered to be full time by custom or industry standards and may vary from school to school.

The Participating Employer acknowledges that current employees will be enrolled effective the date of this Adoption Agreement and will have thirty (30) days from the effective date of this Adoption Agreement to submit a signed enrollment application(s).

The Participating Employer may elect to allow employees who are covered by the plan to waive coverage. If this election is exercised, the Participating Employer will not contribute to the Trust Fund for employees who waive coverage and will sign an Addendum to this Adoption Agreement. The Participating Employer: **(Check one)**

- ☐ Will allow employee coverage waivers
- ☐ Will not allow employee coverage waivers

The Participating Employer's waiting period for employees' coverage will be: **(Check one)**

- ☐ 1 Month
- ☐ 2 Months
- ☐ No Waiting Period
- ☐ If none of the above, enter waiting period: _____

PARTICIPATION ADOPTION AGREEMENT

Employer acknowledges that a waiting period may be changed one time during any calendar year. Employer agrees to notify its employees of the selected waiting period.

The Participating Employer acknowledges that employees are enrolled effective the first of the month following the waiting period set forth above. If No Waiting Period is set forth above, employees' coverage will be effective the first of the month following the employee's date of hire.

The Participating Employer agrees to pay contributions at the rates established from time to time by the Trustees. All bills must be paid as billed and in full. Payment along with fully completed remittances forms are due by the 10th of the month following the month billed (the month of coverage) and subject to liquidated damages as stated in the Trust Agreement if received after the 20th of the month. The Participating Employer will contribute to the Trust Fund for each one of the benefit options selected on Attachment "A" to this Adoption Agreement.

The Participating Employer may not terminate its participation in the Trust Fund during the twelve (12) month period following the effective date of participation or following material change in terms of participation such as a new plan year. At the end of any insurance renewal date thereafter, the Participating Employer may terminate its participation in the Trust Fund by giving written notice of termination to the Trust Fund ninety (90) days in advance of the specific termination date.

The Participating Employer may not terminate a benefit option selected on Attachment "A" to this Adoption Agreement during the benefit option's insurance policy year. At the end of the benefit option's insurance policy year, the Participating Employer may terminate a benefit option by giving written notice to the Trust Fund and submitting a revised Attachment "A" ninety (90) days in advance of the end of the benefit option's insurance policy year.

The Trustees may terminate this Adoption Agreement at any time for the reasons set forth in Article VII, Section 2 of the Trust Agreement, or if continued participation by the Participating Employer would cause the Trust Fund and/or the employee welfare benefit plan(s) to lose tax exempt status. In order to continue participation, the Participating Employer must comply with the participation requirements as set-forth in the CharterLIFE JPA Agreement. Employer agrees to notify its employees of coverage termination whether done by the Trust or by the Employer.

The Participating Employer will fully defend, indemnify and save harmless the Trust Fund and its Trustees, employees, consultants and administrators against any and all loss, damage, liability, claim, demand or suit resulting from injury or harm to any person or property arising out of or in any way connected with the participation of the Participating Employer under this Adoption Agreement. This is intended to include, but is not limited to, claims for expenses incurred due to lack of health coverage due to Employer's failure to make timely premium payments, termination of coverage, employment-related claims, statutory violations, breach of contract claims and claims for damages resulting from personal injury or injury to property.

PARTICIPATION ADOPTION AGREEMENT

The Participating Employer has received the Trust Agreement of the Trust Fund and agrees to be bound to the provisions contained therein, and any future amendments, which are incorporated into this Adoption Agreement by reference as though fully set forth.

Name of Participating Employer: _____

Adoption Agreement Effective Date: _____, 20____

Revised Adoption Agreement Effective Date: _____, 20____

TRUST FUND

_____
Authorized Representative

Administrator
Title

Matthew Schafer
Print Name

_____
Date

Address of Trust

80 Iron Point Circle, Suite 200

Folsom, Ca 95630

PARTICIPATING EMPLOYER

_____
Authorized Representative

_____
Title

_____
Print Name

_____
Date

Address of Participating Employer

_____

_____

_____
Employer Identification Number

_____
CA Department of Education's CDS CODE

ADDENDUM TO ADOPTION AGREEMENT OF EMPLOYER ALLOWING EMPLOYEES TO WAIVE COVERAGE

This Addendum is made to the Adoption Agreement between _____ _____ ("Participating Employer") and the California Charter Schools Association Employee Welfare Benefit Trust, dba CharterLIFE™ ("Trust Fund") signed by the Participating Employer on _____, 20___.

The Participating Employer has elected not to contribute to the Trust Fund for employees who waive coverage. The Adoption Agreement requires the participating Employer to agree to the terms of this Addendum.

The Participating Employer will contribute to the Trust Fund for all employees except those who waive coverage in writing by signing the Trust Fund's declination of coverage form. In the event that the Trust Fund reviews the payroll records of the Participating Employer, all declination of coverage forms must be presented to the Trust Fund auditor for review. Contribution payments must be made by the Participating Employer for all covered employees except those who have signed declination of coverage forms. It is the responsibility of the Participating Employer to maintain copies of these forms for no fewer than six (6) years after they are signed.

Except as required by the Patient Protection and Affordable Care Act, Employees may only decline coverage if they are: (1) covered as a dependent under another group health benefit plan through their spouses or domestic partners; or (2) are covered under a military health plan, Medicare or Medicaid. It is the responsibility of the Participating Employer to obtain written proof of alternate insurance coverage by employees declining coverage. The Participating Employer must also provide the Trust Fund auditor with copies of the proof of alternate insurance during any payroll record review.

It is the responsibility of the Participating Employer to immediately notify the Trust Fund of any change in status of employees who have declined coverage. The Trust Fund has no obligation to communicate with the Participating Employer's employees about their alternate coverage or their declination of coverage. This is a responsibility of the Participating Employer.

The Participating Employer will fully defend, indemnify and save harmless the Trust Fund and its Trustees, employees and administrators against any and all loss, damage, liability, claim, demand or suit resulting from injury or harm to any person or property arising out of or in any way connected with the participation of the Participating Employer under this Addendum to the Adoption Agreement. This is intended to include, but is not limited to, employment-related claims, statutory violations, breach of contract claims, claims for health and welfare and/or medical benefits of any type, resulting from any medical condition, illness, personal injury or injury to property.

ADDENDUM TO ADOPTION AGREEMENT OF EMPLOYER

ALLOWING EMPLOYEES TO WAIVE COVERAGE

The Participating Employer also agrees that any dispute arising under this Addendum, involving itself or any employee, will be subject to the Plan's claim and appeal process. Any Participating Employer, participant, dependent or beneficiary adversely affected by any action of the Trust Fund or its Trustees under this Addendum will be entitled, within sixty (60) days after being apprised of the Trustees' decision leading to such adverse action, request the Trustees in writing to conduct a review as per the claim and appeal process. The Trustees will allow the aggrieved party to submit any additional information and the Trustees can conduct a hearing thereafter if the Trustees in their sole discretion so elect. If a hearing is held the Employer, and any participating employee, dependent or beneficiary may present his position against the adverse action. If no hearing is held the Trustees will make their decision based on the written evidence and written argument presented. The Participating Employer, participating employee, beneficiary or dependent may be represented by an attorney or other individual designated at the election and in the sole discretion of the Trustees. The Trustees will issue a written decision within sixty (60) concerning their ruling following the hearing if one is granted. The decision of the Trustees, if adverse, may be challenged in Federal District Court for abuse of discretion.

The parties' signatory to this ADDENDUM to ADOPTION AGREEMENT is as follows:

TRUST FUND	**PARTICIPATING EMPLOYER**
By: _____ Authorized Representative	By: _____ Authorized Representative
By: _____*Matthew Schafer*_____ Print name	By: _____ Print name
Title:_____*Administrator*_____	Title:_____
Date:_____	Date:_____

ADOPTION AGREEMENT ATTACHMENT "A"

Participating Employer's Selection of Benefit Options

Participating Employer: _____

Medical Benefits

Anthem Blue Cross

- ☐ EPO High Option — Effective Date: _____
- ☐ EPO Low Option — Effective Date: _____
- ☐ EPO Base Option — Effective Date: _____
- ☐ PPO High Option — Effective Date: _____
- ☐ PPO Low Option — Effective Date: _____
- ☐ PPO Base Option — Effective Date: _____

Kaiser Foundation Health Plans, Inc.

- ☐ HMO High Option — Effective Date: _____
- ☐ HMO Low Option — Effective Date: _____
- ☐ HMO $1500 High Deductible — Effective Date: _____
- ☐ HMO $3000 HRA — Effective Date: _____

Dental Benefits

- ☐ DeltaCare HMO — Effective Date: _____
- ☐ Delta Dental PPO 1000 — Effective Date: _____
- ☐ Delta Dental PPO 2000 — Effective Date: _____

Vision Benefits

- ☐ VSP Vision — Effective Date: _____

Life Insurance Benefits

Unum – May offer one Group Life, AD&D and EAP plan *(select only one option)*

- ☐ $25,000 Group Life, AD&D and EAP — Effective Date: _____
- ☐ $50,000 Group Life, AD&D and EAP — Effective Date: _____
- ☐ 2X Salary Up to $150k Group Life, AD&D and EAP — Effective Date: _____

Participating Employer:

Signature: _____ Date: _____

Print Name: _____ Title: _____

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2024

Rate Sheet

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Kaiser Rates

CharterLIFE™ Renewal Rates 2024				SCq3
Tier	Kaiser HMO High	Kaiser HMO Low	Kaiser HMO HDP $1500	Kaiser HMO HRA $3000
Employee Only	$917.74	$842.91	$787.15	$570.42
Employee+1				
EE + Sp	$2,019.03	$1,854.41	$1,731.73	$1,254.92
EE + Chld/ren	$1,651.93	$1,517.23	$1,416.86	$1,026.74
Family	$2,845.00	$2,613.02	$2,440.16	$1,768.29
Total EE's				

Anthem Rates

CharterLIFE™ Renewal Rates 2024				SCq3	FINAL	
Tier	BC EPO High	BC EPO Low	BC EPO Base	BC PPO High	BC PPO Low	BC PPO Base
Employee Only	$798.81	$730.03	$676.30	$1,319.19	$1,213.92	$944.42
Employee+1						
EE + Sp	$1,757.39	$1,606.08	$1,487.86	$2,902.24	$2,670.66	$2,077.70
EE + Chld/ren	$1,437.86	$1,314.06	$1,217.37	$2,374.56	$2,185.08	$1,699.95
Family	$2,475.89	$2,263.11	$2,096.55	$4,089.52	$3,763.20	$2,927.69
Total EE's						

Dental / Vision / Life

CharterLIFE™ Renewal Rates 2024				SCq3	FINAL	
Tier	Dental PPO 2000	Dental PPO 1000	DeltaCare HMO	VSP VISION	Life 25,000	Life 50,000
Employee Only	$58.69	$51.18	$14.81	$9.47	$2.68	$5.37
Employee+1	$114.12	$95.30	$28.20	$18.84		
EE + Sp						
EE + Chld/ren					-	
Family	$188.50	$156.62	$45.51	$30.66		
Total EE's						

CharterLIFE™
Believe Build Benefit

Carrier Plan Summaries

CharterLIFE™
Believe Build Benefit

Anthem Blue Cross High PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.brmsclaims.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.brmsclaims.com or call 1-866-755-6651 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In-Network: $500** Individual / **$1,000** Family **Out of Network: $1,000** Individual / **$2,000** Family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Yes.** Preventive care services, office visits, prescription drugs, and Telemedicine visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**In-Network: $1,500** Individual / **$3,000** Family **Out of Network: $3,000** Individual / **$6,000** Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization, infertility treatment and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes.** See www.anthem.com/ca or call Benefit & Risk Management Services at 1-866-755-6651 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay / visit deductible does not apply	30% coinsurance	None
	Specialist visit	$20 copay / visit deductible does not apply		
	Preventive care/screening/ immunization	No charge	30% coinsurance	None
	Anthem Live Health Online	No copay / visit deductible does not apply	30% coinsurance	Telemedicine services provided by a primary care physician or specialist will be covered the same as any other office visit with that provider.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	30% coinsurance	$800 maximum / service for Non-Network Providers.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	Tier1a: Retail: $5 copay / prescription Mail Order: $12.50 copay / prescription Tier1b: Retail: $15 copay / prescription Mail Order: $37.50 copay / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)
	Preferred brand drugs	Retail: $25 copay / prescription Mail Order: $75 copay / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)
	Non-preferred brand drugs	Retail: $45 copay / prescription Mail Order: $135 copay / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)
	Specialty drugs	Retail & Mail Order: 30% coinsurance up to $250 per prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply. Specialty drugs must be obtained through US Specialty Care Pharmacy (USSC) after one fill at a participating retail pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	30% coinsurance	$350 maximum / service for Non-Network Providers
	Physician/surgeon fees	10% coinsurance after deductible	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 / visit then 10% coinsurance after deductible	Covered as In-Network	Copay waived if admitted. 10% coinsurance for Emergency Room Physician Fee.
	Emergency medical transportation	10% coinsurance after deductible	Covered as In-Network	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	$20 copay / office visit Deductible does not apply	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	30% coinsurance	$1,000 maximum / day for Non-Emergency Admissions to Non-Network Providers
	Physician/surgeon fees	10% coinsurance after deductible	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay / office visit 10% coinsurance after deductible / outpatient	30% coinsurance	None
	Inpatient services	10% coinsurance after deductible	30% coinsurance	$1,000 maximum/day for Non-Emergency Admissions to Non-Network Providers. 10% coinsurance for Inpatient Physician Fee In-Network Providers. 30% coinsurance for Inpatient Physician Fee Non-Network Providers.
If you are pregnant	Office visits	$20 copay / initial visit deductible does not apply	30% coinsurance	$1,000 maximum/day for Non-Emergency Admissions to Non-Network Providers. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). *Coverage includes fertility preservation services, see Fertility Preservation section.
	Childbirth/delivery professional services	10% coinsurance after deductible	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance after deductible	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	30% coinsurance	100 visits/benefit period one visit by a home health aide equals four hours or less.
	Rehabilitation services	10% coinsurance after deductible	30% coinsurance	*See Therapy Services section.
	Habilitation services	10% coinsurance after deductible	30% coinsurance	*See Therapy Services section.
	Skilled nursing care	10% coinsurance after deductible	30% coinsurance	Must commence within 14 days of an inpatient hospital stay that is at least 3 days. Limited to 100 days per calendar year.
	Durable medical equipment	10% coinsurance after deductible	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	No copay / visit deductible does not apply	30% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Refer to Vision Plan
	Children's glasses	Not Covered	Not Covered	Refer to Vision Plan
	Children's dental check-up	Not Covered	Not Covered	Refer to Dental Plan

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental check-up
- Dental care (Adult)
- Eye exams for a child
- Infertility treatment
- Long term care
- Glasses for a child
- Dental care (Pediatric)
- Routine eye care (Adult)
- Routine foot care unless you have been diagnosed with diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture 20 visits / benefit period
- Hearing aids
- Bariatric surgery
- Private duty nurse (In-Network only)
- Chiropractic care 30 visits/benefit period
- Most coverage provided outside the United States. See www.bcbsglobalcore.com

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the plan at 1-866-755-6651, the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or https://www.cms.gov/cciio. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit https://www.healthcare.gov/ or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the plan at 1-866-755-6651. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 866-755-6651.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-755-6651.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 866-755-6651.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 866-755-6651.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other (generic pharmacy) copayment	$10

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,738**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,970**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other (brand pharmacy) copayment	$30

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$800
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,400**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copay	$50
Hospital (facility) coinsurance	20%
Other (DME) coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

The plan would be responsible for the other costs of these EXAMPLE covered services.

CharterLIFE™
Believe Build Benefit

Anthem Blue Cross Low PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.brmsclaims.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.brmsclaims.com or call 1-866-755-6651 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In-Network: $1,500** Individual / **$3,000** Family **Out of Network: $4,500** Individual / **$9,000** Family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Yes.** Preventive care services, office visits, prescription drugs, and Telemedicine visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $150/person or $450/family for Prescription Drug Tiers 2, 3 and 4. There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**In-Network: $3,500** Individual / **$7,000** Family **Out of Network: $10,500** Individual / **$21,000** Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization, infertility treatment and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes.** See www.anthem.com/ca or call Benefit & Risk Management Services at 1-866-755-6651 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay / visit deductible does not apply	40% coinsurance	None
	Specialist visit	$15 copay / visit deductible does not apply		
	Preventive care/screening/ immunization	No charge	40% coinsurance	None
	Anthem Live Health Online	No copay / visit deductible does not apply	40% coinsurance	Telemedicine services provided by a primary care physician or specialist will be covered the same as any other office visit with that provider.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance	$800 maximum / service for Non-Network Providers.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	Retail: $10 copay / prescription Mail Order: $25 copay / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)
	Preferred brand drugs	Retail: $35 copay / prescription Mail Order: $105 copay / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)
	Non-preferred brand drugs	Retail: $70 copay / prescription Mail Order: $210 copay / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	Retail & Mail Order: 30% coinsurance up to $250 per prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply. Specialty drugs must be obtained through US Specialty Care Pharmacy (USSC) after one fill at a participating retail pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance	$350 maximum / service for Non-Network Providers
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 / visit then 20% coinsurance after deductible	Covered as In-Network	Copay waived if admitted. 10% coinsurance for Emergency Room Physician Fee.
	Emergency medical transportation	20% coinsurance after deductible	Covered as In-Network	None
	Urgent care	$15 copay / office visit	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance	$1,000 maximum / day for Non-Emergency Admissions to Non-Network Providers
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay / office visit 20% coinsurance after deductible / outpatient	40% coinsurance	None
	Inpatient services	20% coinsurance after deductible	40% coinsurance	$1,000 maximum/day for Non-Emergency Admissions to Non-Network Providers. 10% coinsurance for Inpatient Physician Fee In-Network Providers. 30% coinsurance for Inpatient Physician Fee Non-Network Providers.
If you are pregnant	Office visits	$15 copay / initial visit deductible does not apply	40% coinsurance	$1,000 maximum/day for Non-Emergency Admissions to Non-Network Providers.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). *Coverage includes fertility preservation services, see Fertility Preservation section.
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance	100 visits/benefit period one visit by a home health aide equals four hours or less.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance	*See Therapy Services section.
	Habilitation services	20% coinsurance after deductible	40% coinsurance	*See Therapy Services section.
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance	Must commence within 14 days of an inpatient hospital stay that is at least 3 days. Limited to 100 days per calendar year.
	Durable medical equipment	50% coinsurance after deductible	50% coinsurance	None
	Hospice services	No copay / visit deductible does not apply	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Refer to Vision Plan
	Children's glasses	Not Covered	Not Covered	Refer to Vision Plan
	Children's dental check-up	Not Covered	Not Covered	Refer to Dental Plan

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental check-up
- Dental care (Adult)
- Eye exams for a child
- Infertility treatment
- Long term care
- Glasses for a child
- Dental care (Pediatric)
- Routine eye care (Adult)
- Routine foot care unless you have been diagnosed with diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture 20 visits / benefit period
- Hearing aids
- Bariatric surgery
- Private duty nurse (In-Network only)
- Chiropractic care 30 visits/benefit period
- Most coverage provided outside the United States. See www.bcbsglobalcore.com

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the plan at 1-866-755-6651, the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or https://www.cms.gov/cciio. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit https://www.healthcare.gov/ or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the plan at 1-866-755-6651. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 866-755-6651.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-755-6651.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 866-755-6651.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 866-755-6651.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other (generic pharmacy) copayment	$10

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,738**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,970**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other (brand pharmacy) copayment	$30

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$800
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,400**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copay	$50
Hospital (facility) coinsurance	20%
Other (DME) coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

The plan would be responsible for the other costs of these EXAMPLE covered services.

CharterLIFE™
Believe Build Benefit

Anthem Blue Cross Base PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.brmsclaims.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.brmsclaims.com or call 1-866-755-6651 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In-Network: $6,100** Individual / **$12,200** Family **Out of Network: $18,300** Individual / **$36,600** Family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Yes.** Preventive care services, office visits, prescription drugs, and Telemedicine visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**In-Network: $6,400** Individual / **$12,800** Family **Out of Network: $19,200** Individual / **$38,400** Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization, infertility treatment and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes.** See www.anthem.com/ca or call Benefit & Risk Management Services at 1-866-755-6651 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance after deductible	50% coinsurance	None
	Specialist visit	0% coinsurance after deductible		
	Preventive care/screening/ immunization	No charge	50% coinsurance	None
	Anthem Live Health Online	No copay / visit deductible does not apply	50% coinsurance	Telemedicine services provided by a primary care physician or specialist will be covered the same as any other office visit with that provider.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance after deductible	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance after deductible	50% coinsurance	$800 maximum / service for Non-Network Providers.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	Tier1a: Retail: $5 copay / prescription Mail Order: $12.50 copay / prescription Tier1b: Retail: $15 copay / prescription Mail Order: $37.50 copay / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)
	Preferred brand drugs	Retail: $50 copay / prescription Mail Order: $150 copay / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)
	Non-preferred brand drugs	Retail: $65 copay / prescription Mail Order: $195 copay / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)
	Specialty drugs	Retail & Mail Order: 30% coinsurance up to $250 per prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply. Specialty drugs must be obtained through US Specialty Care Pharmacy (USSC) after one fill at a participating retail pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	50% coinsurance	$350 maximum / service for Non-Network Providers
	Physician/surgeon fees	0% coinsurance after deductible	50% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance after deductible	Covered as In-Network	Copay waived if admitted. 10% coinsurance for Emergency Room Physician Fee.
	Emergency medical transportation	0% coinsurance after deductible	Covered as In-Network	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	0% coinsurance after deductible	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after deductible	50% coinsurance	$1,000 maximum / day for Non-Emergency Admissions to Non-Network Providers
	Physician/surgeon fees	0% coinsurance after deductible	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance after deductible	50% coinsurance	None
	Inpatient services	0% coinsurance after deductible	50% coinsurance	$1,000 maximum/day for Non-Emergency Admissions to Non-Network Providers. 10% coinsurance for Inpatient Physician Fee In-Network Providers. 30% coinsurance for Inpatient Physician Fee Non-Network Providers.
If you are pregnant	Office visits	0% coinsurance after deductible	50% coinsurance	$1,000 maximum/day for Non-Emergency Admissions to Non-Network Providers. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). *Coverage includes fertility preservation services, see Fertility Preservation section.
	Childbirth/delivery professional services	0% coinsurance after deductible	50% coinsurance	
	Childbirth/delivery facility services	0% coinsurance after deductible	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible	50% coinsurance	100 visits/benefit period one visit by a home health aide equals four hours or less.
	Rehabilitation services	0% coinsurance after deductible	50% coinsurance	*See Therapy Services section.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	0% coinsurance after deductible	50% coinsurance	*See Therapy Services section.
	Skilled nursing care	0% coinsurance after deductible	50% coinsurance	Must commence within 14 days of an inpatient hospital stay that is at least 3 days. Limited to 100 days per calendar year.
	Durable medical equipment	0% coinsurance after deductible	50% coinsurance	None
	Hospice services	0% coinsurance after deductible	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Refer to Vision Plan
	Children's glasses	Not Covered	Not Covered	Refer to Vision Plan
	Children's dental check-up	Not Covered	Not Covered	Refer to Dental Plan

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental check-up
- Dental care (Adult)
- Eye exams for a child
- Infertility treatment
- Long term care
- Glasses for a child
- Dental care (Pediatric)
- Routine eye care (Adult)
- Routine foot care unless you have been diagnosed with diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture 20 visits / benefit period
- Hearing aids
- Bariatric surgery
- Private duty nurse (In-Network only)
- Chiropractic care 30 visits/benefit period
- Most coverage provided outside the United States. See www.bcbsglobalcore.com

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the plan at 1-866-755-6651, the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or https://www.cms.gov/cciio. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit https://www.healthcare.gov/ or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the plan at 1-866-755-6651. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 866-755-6651.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-755-6651.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 866-755-6651.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 866-755-6651.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other (generic pharmacy) copayment	$10

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,738**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,970**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other (brand pharmacy) copayment	$30

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$800
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,400**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copay	$50
Hospital (facility) coinsurance	20%
Other (DME) coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

The plan would be responsible for the other costs of these EXAMPLE covered services.

CharterLIFE™
Believe Build Benefit

Anthem Blue Cross High EPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.brmsclaims.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.brmsclaims.com or call 1-866-755-6651 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**None**	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**No.**	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$2,000** Individual / **$4,000** Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization, infertility treatment and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes.** See www.anthem.com/ca or call Benefit & Risk Management Services at 1-866-755-6651 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay / visit deductible does not apply	Not Covered	None
	Specialist visit	$30 copay / visit deductible does not apply		
	Preventive care/screening/ immunization	No charge	Not Covered	None
	Anthem Live Health Online	$10 copay / visit deductible does not apply	Not Covered	Telemedicine services provided by a primary care physician or specialist will be covered the same as any other office visit with that provider.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	$100 / test	Not Covered	Some services may require preauthorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com	Generic drugs	Tier1a: Retail: $5 copay / prescription Mail Order: $12.50 copay / prescription Tier1b: Retail: $15 copay / prescription Mail Order: $37.50 copay / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)
	Preferred brand drugs	Retail: $30 copay / prescription Mail Order: $90 copay / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)
	Non-preferred brand drugs	Retail: $50 copay / prescription Mail Order: $150 copay / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	Retail & Mail Order: 30% coinsurance up to $250 / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply. Specialty drugs must be obtained through US Specialty Care Pharmacy (USSC) after one fill at a participating retail pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$125 / visit	Not Covered	Some procedures may require preauthorization.
	Physician/surgeon fees	No Charge	Not Covered	Some procedures may require preauthorization.
If you need immediate medical attention	Emergency room care	$100 / visit	Covered as In-Network	Inpatient services require preauthorization to avoid a $400 penalty per occurrence.
	Emergency medical transportation	$100 / trip	Covered as In-Network	None
	Urgent care	$10 / visit	Covered as In-Network	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / admission	Not Covered	Services require preauthorization to avoid $400 penalty per occurrence.
	Physician/surgeon fees	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay / office visit	Not Covered	None
	Inpatient services	$250 / admission	Not Covered	Services require preauthorization to avoid $400 penalty.
If you are pregnant	Office visits	$10 copay / visit	Not Covered	Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	No Charge	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	$250 / admission	Not Covered	Preauthorization is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				more than a 96 hour stay to avoid a $400 penalty.
If you need help recovering or have other special health needs	Home health care	$10 copay / visit	Not Covered	Services require preauthorization to avoid $400 penalty.
	Rehabilitation services	$10 copay / visit	Not Covered	None
	Habilitation services	$10 copay / visit	Not Covered	None
	Skilled nursing care	No Charge	Not Covered	Must commence within 14 days of an inpatient hospital stay that is at least 3 days. Limited to 100 days per calendar year. Services require preauthorization to avoid $400 penalty.
	Durable medical equipment	20% coinsurance	Not Covered	None
	Hospice services	No Charge	Not Covered	Limited to 210 days per lifetime. Includes 15 family bereavement counseling sessions. Services require preauthorization to avoid $400 penalty.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental check-up
- Dental care (Adult)
- Eye exams for a child
- Infertility treatment
- Long term care
- Glasses for a child
- Dental care (Pediatric)
- Routine eye care (Adult)
- Routine foot care unless you have been diagnosed with diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture 20 visits / benefit period
- Hearing aids
- Bariatric surgery
- Private duty nurse (In-Network only)
- Chiropractic care 30 visits/benefit period
- Most coverage provided outside the United States. See www.bcbsglobalcore.com

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the plan at 1-866-755-6651, the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or https://www.cms.gov/cciio. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit https://www.healthcare.gov/ or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the plan at 1-866-755-6651. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 866-755-6651.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-755-6651.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 866-755-6651.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 866-755-6651.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other (generic pharmacy) copayment	$10

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,738**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,970**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other (brand pharmacy) copayment	$30

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$800
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,400**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copay	$50
Hospital (facility) coinsurance	20%
Other (DME) coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

The plan would be responsible for the other costs of these EXAMPLE covered services.

CharterLIFE™
Believe Build Benefit

Anthem Blue Cross Low EPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.brmsclaims.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.brmsclaims.com or call 1-866-755-6651 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**None**	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**No.**	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. $150 / person or $450 / family for Prescription Drugs Tiers 2, 3, and 4.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$2,500** Individual / **$5,000** Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Infertility services, premiums, balance-billed charges, penalties for failure to obtain pre-authorization, infertility treatment and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes.** See www.anthem.com/ca or call Benefit & Risk Management Services at 1-866-755-6651 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay / visit	Not Covered	None
	Specialist visit	$40 copay / visit		
	Preventive care/screening/ immunization	No charge	Not Covered	None
	Anthem Live Health Online	$30 copay / visit deductible does not apply	Not Covered	Telemedicine services provided by a primary care physician or specialist will be covered the same as any other office visit with that provider.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	$100 / service	Not Covered	Some services may require preauthorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	Tier1a: Retail: $5 copay / prescription Mail Order: $12.50 copay / prescription Tier1b: Retail: $15 copay / prescription Mail Order: $37.50 copay / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)
	Preferred brand drugs	Retail: $25 copay / prescription Mail Order: $75 copay / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)
	Non-preferred brand drugs	Retail: $45 copay / prescription Mail Order: $135 copay / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	Retail & Mail Order: 30% coinsurance up to $250 / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply. Specialty drugs must be obtained through US Specialty Care Pharmacy (USSC) after one fill at a participating retail pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 / visit	Not Covered	Some procedures may require preauthorization.
	Physician/surgeon fees	No Charge	Not Covered	Some procedures may require preauthorization.
If you need immediate medical attention	Emergency room care	$100 / visit	Covered as In-Network	Inpatient services require preauthorization to avoid a $400 penalty per occurrence.
	Emergency medical transportation	$100 / trip	Covered as In-Network	None
	Urgent care	$30 / visit	Covered as In-Network	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 / admission	Not Covered	Services require preauthorization to avoid $400 penalty per occurrence.
	Physician/surgeon fees	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay / office visit	Not Covered	None
	Inpatient services	$500 / admission	Not Covered	Services require preauthorization to avoid $400 penalty.
If you are pregnant	Office visits	$30 copay / visit	Not Covered	Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	No Charge	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	$500 / admission	Not Covered	Preauthorization is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				more than a 96 hour stay to avoid a $400 penalty.
If you need help recovering or have other special health needs	Home health care	$30 copay / visit	Not Covered	Services require preauthorization to avoid $400 penalty.
	Rehabilitation services	$30 copay / visit	Not Covered	None
	Habilitation services	$30 copay / visit	Not Covered	None
	Skilled nursing care	No Charge	Not Covered	Must commence within 14 days of an inpatient hospital stay that is at least 3 days. Limited to 100 days per calendar year. Services require preauthorization to avoid $400 penalty.
	Durable medical equipment	20% coinsurance	Not Covered	None
	Hospice services	No Charge	Not Covered	Limited to 210 days per lifetime. Includes 15 family bereavement counseling sessions. Services require preauthorization to avoid $400 penalty.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental check-up
- Dental care (Adult)
- Eye exams for a child
- Infertility treatment
- Long term care
- Glasses for a child
- Dental care (Pediatric)
- Routine eye care (Adult)
- Routine foot care unless you have been diagnosed with diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture 20 visits / benefit period
- Hearing aids
- Bariatric surgery
- Private duty nurse (In-Network only)
- Chiropractic care 30 visits/benefit period
- Most coverage provided outside the United States. See www.bcbsglobalcore.com

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the plan at 1-866-755-6651, the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or https://www.cms.gov/cciio. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit https://www.healthcare.gov/ or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the plan at 1-866-755-6651. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 866-755-6651.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-755-6651.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 866-755-6651.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 866-755-6651.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other (generic pharmacy) copayment	$10

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,738**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,970**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other (brand pharmacy) copayment	$30

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$800
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,400**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copay	$50
Hospital (facility) coinsurance	20%
Other (DME) coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.brmsclaims.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.brmsclaims.com or call 1-866-755-6651 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**None**	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**No.**	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. $150 / person or $450 / family for Prescription Drugs Tiers 2, 3, and 4.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$2,500** Individual / **$5,000** Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Infertility services, premiums, balance-billed charges, penalties for failure to obtain pre-authorization, infertility treatment and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes.** See www.anthem.com/ca or call Benefit & Risk Management Services at 1-866-755-6651 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay / visit	Not Covered	None
	Specialist visit	$45 copay / visit		
	Preventive care/screening/ immunization	No charge	Not Covered	None
	Anthem Live Health Online	$35 copay / visit deductible does not apply	Not Covered	Telemedicine services provided by a primary care physician or specialist will be covered the same as any other office visit with that provider.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	$100 / service	Not Covered	Some services may require preauthorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	Tier1a: Retail: $5 copay / prescription Mail Order: $12.50 copay / prescription Tier1b: Retail: $15 copay / prescription Mail Order: $37.50 copay / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)
	Preferred brand drugs	Retail: $30 copay / prescription Mail Order: $90 copay / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)
	Non-preferred brand drugs	Retail: $50 copay / prescription Mail Order: $150 copay / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	Retail & Mail Order: 30% coinsurance up to $250 / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply. Specialty drugs must be obtained through US Specialty Care Pharmacy (USSC) after one fill at a participating retail pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$375 / visit	Not Covered	Some procedures may require preauthorization.
	Physician/surgeon fees	No Charge	Not Covered	Some procedures may require preauthorization.
If you need immediate medical attention	Emergency room care	$100 / visit	Covered as In-Network	Inpatient services require preauthorization to avoid a $400 penalty per occurrence.
	Emergency medical transportation	$100 / trip	Covered as In-Network	None
	Urgent care	$35 / visit	Covered as In-Network	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$750 / admission	Not Covered	Services require preauthorization to avoid $400 penalty per occurrence.
	Physician/surgeon fees	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay / office visit	Not Covered	None
	Inpatient services	$750 / admission	Not Covered	Services require preauthorization to avoid $400 penalty.
If you are pregnant	Office visits	$35 copay / visit	Not Covered	Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	No Charge	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	$750 / admission	Not Covered	Preauthorization is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				more than a 96 hour stay to avoid a $400 penalty.
If you need help recovering or have other special health needs	Home health care	$35 copay / visit	Not Covered	Services require preauthorization to avoid $400 penalty.
	Rehabilitation services	$35 copay / visit	Not Covered	None
	Habilitation services	$35 copay / visit	Not Covered	None
	Skilled nursing care	No Charge	Not Covered	Must commence within 14 days of an inpatient hospital stay that is at least 3 days. Limited to 100 days per calendar year. Services require preauthorization to avoid $400 penalty.
	Durable medical equipment	20% coinsurance	Not Covered	None
	Hospice services	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental check-up
- Dental care (Adult)
- Eye exams for a child
- Infertility treatment
- Long term care
- Glasses for a child
- Dental care (Pediatric)
- Routine eye care (Adult)
- Routine foot care unless you have been diagnosed with diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture 20 visits / benefit period
- Hearing aids
- Bariatric surgery
- Private duty nurse (In-Network only)
- Chiropractic care 30 visits/benefit period
- Most coverage provided outside the United States. See www.bcbsglobalcore.com

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the plan at 1-866-755-6651, the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or https://www.cms.gov/cciio. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit https://www.healthcare.gov/ or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the plan at 1-866-755-6651. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 866-755-6651.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-755-6651.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 866-755-6651.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 866-755-6651.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other (generic pharmacy) copayment	$10

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,738**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,970**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other (brand pharmacy) copayment	$30

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$800
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,400**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copay	$50
Hospital (facility) coinsurance	20%
Other (DME) coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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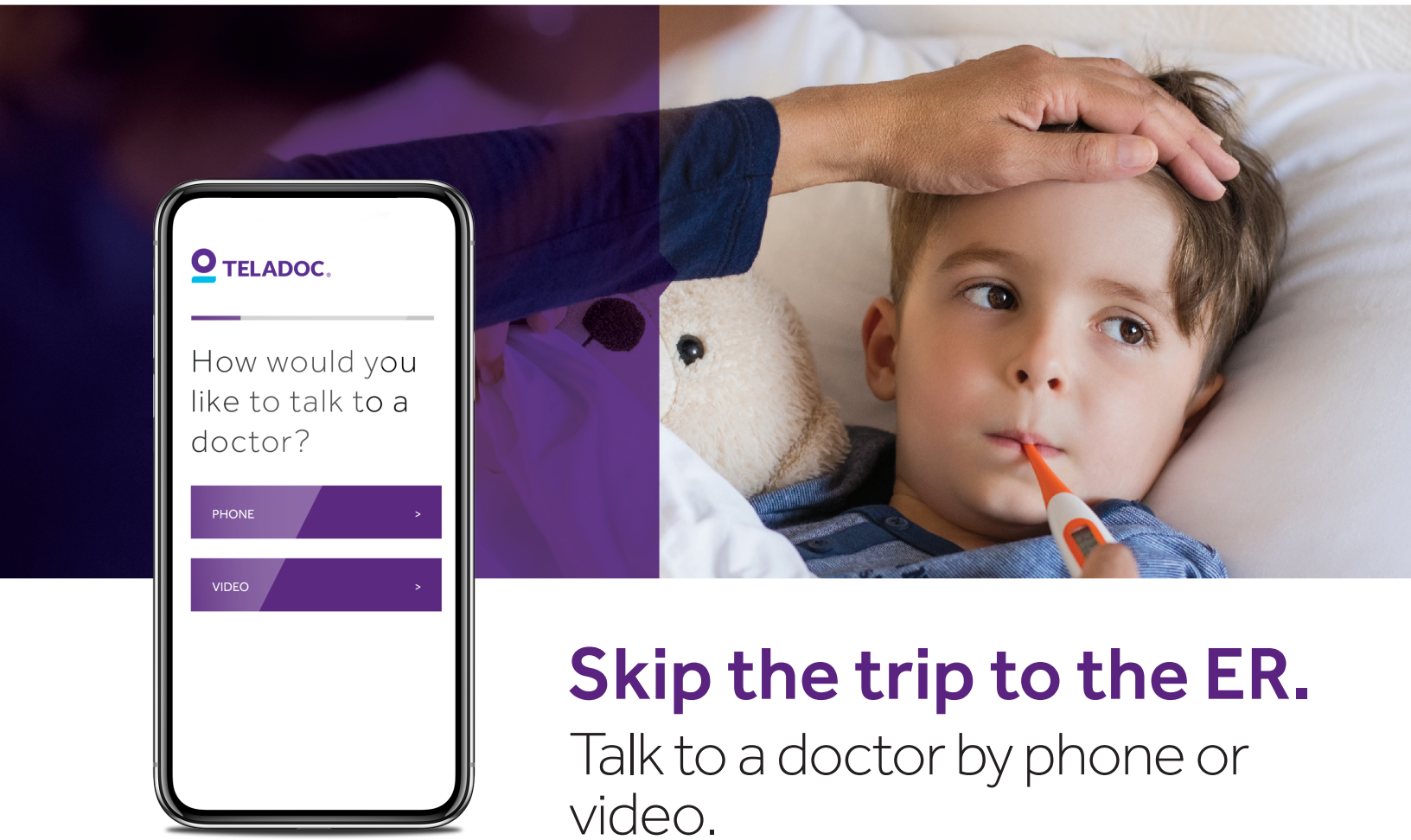

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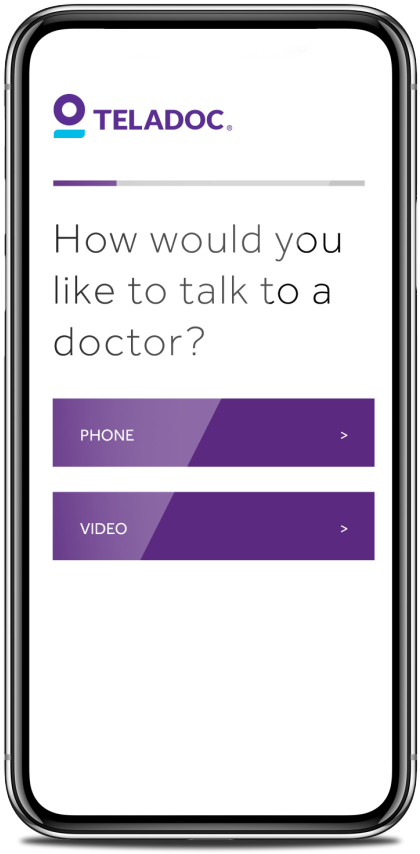

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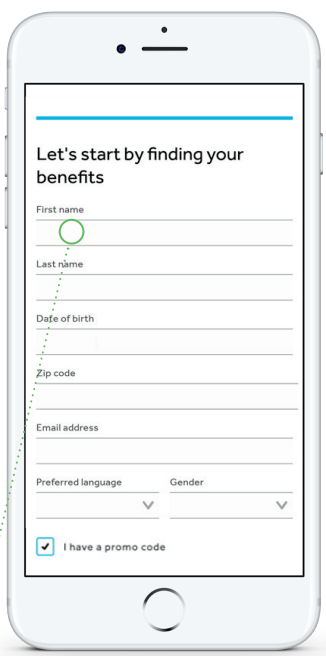
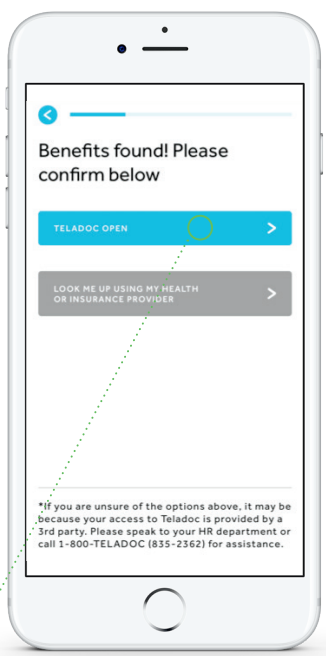


1. Confirm benefits

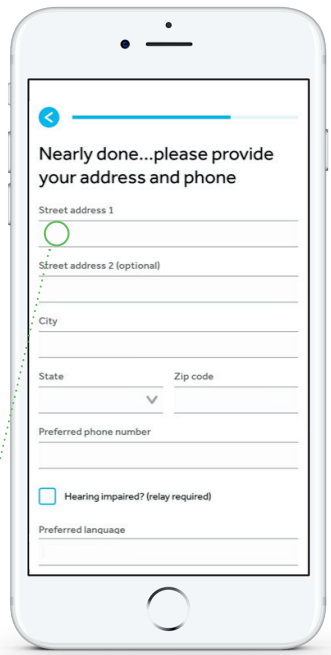
Provide some information about yourself to confirm your eligibility.



2. Benefit confirmation

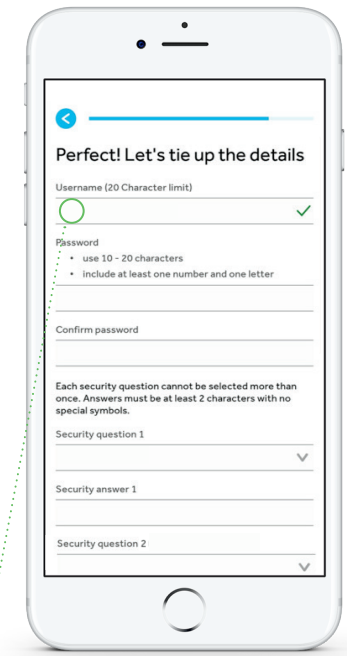
We'll confirm that we found your benefits and you'll continue creating your account.

TELADOC®



3. Create account

Please provide your contact information and preferred language.



4. Complete account

Create a username, password, and pick security questions to ensure your account is secure.

Talk to a doctor anytime for free

1-800-TELADOC (835-2362) | Download the app | Teladoc.com

Let us bring your medications to you

With Optum® Home Delivery, you can get a 3-month supply of your long-term medications. Plus, we mail them to you with free standard shipping.

Want more reasons?

Skip the trips

We deliver your medication to your door. You don't even have to leave home or wait in the pharmacy line.

Save money

You may pay less than what you do at in-store pharmacies. And, standard shipping is free.

Stay on track

With a 3-month supply, you may be less likely to miss a dose. You can even sign up for automatic refills.

Flexible Payment Options

Make one payment upfront. Or split it up into 3 equal monthly payments.

We're here when you need us

Use the website and app any time to track orders, request refills, price medications and more. Pharmacists and customer support team are available 24/7.

Ready for home delivery?

Here are the ways to sign up.

- **optumrx.com** or with the Optum Rx app.
- Or ask your doctor to send an electronic prescription to Optum Rx.
- Or call the number on your member ID card.

Scan code. Log in. Sign up.

Optum

Frequently Asked Questions

Is the Optum Home Delivery pharmacy in my plan's network?

Yes, it's part of your plan's pharmacy network.

Once I've enrolled in home delivery, how long will it take to get my medication(s)?

Medications should arrive within 5 business days after we receive the complete order.

Do I need to set up a home delivery account?

Yes. Before we can ship your first order, you need to set up your account and provide your payment method (credit card, debit card or bank account). Using your account, you can go online or use the app any time to place and track orders, check prices, and more.

What is a long-term medication?

Long-term medications are those you take on a regular basis. These may be taken for high blood pressure, cholesterol, and depression, just to name a few.

Can I use home delivery for any medication?

Use home delivery for long-term medications. See which of your prescriptions can be filled through home delivery by going online or using the app.

Can I set up medication reminders?

Yes. Go online or use the app to check your profile and turn on email and phone notifications and reminders.

How does the automatic refill program work?

Go online or use the app to see and enroll all eligible medications. Then, we'll send your refills when it's time. We notify you before we ship and we'll use your approved payment method on file. It's that easy.

Confused about health care terms? Visit **justplainclear.com.**

Sign up for home delivery today

Log in to **optumrx.com** or use the Optum Rx app

Optum

Optum Rx®

Get smart about prescriptions

Our online tools make it easy

Visit **optumrx.com** to register your account. You'll need information from your member ID card to sign up and access your account details and prescriptions.

Price a drug – Search your current or new medications to see costs at pharmacies near you. If you're taking a brand-name drug, you can also see prices for generic options.

My prescriptions – See your current prescriptions along with information about how to use them and possible side effects.

View my claims – See which prescriptions you've filled and how much you paid.

Pharmacy locator – Search for network pharmacies near you – or find a pharmacy when you're traveling.

Manage prescriptions on-the-go – For added convenience, download the **Optum Rx app.**

To learn more today, scan this code with your phone's camera and click on the link or go to **optumrx.com/getstarted** for info on Optum Rx.

Optum

Optum Rx®

Welcome to your specialty pharmacy

Optum Rx offers specialty medication support through Optum Specialty Pharmacy so that you can get specialty prescriptions and personalized support the way you want it.

What is a specialty medication?

A specialty medication may be injected, infused, taken by mouth or inhaled. It's different from other medication because it:

- May need ongoing clinical oversight and extra education
- May have unique storage or shipping needs
- May not be filled at retail pharmacies
- May need infusion or home nursing

What services does the specialty pharmacy provide?

You'll get access to these helpful resources.

Easy prescriptions

- Get medications delivered on time, accurately, and affordably
- Order refills by phone or online*
- Receive support through virtual visits, calls, live chat, or text

Expert guidance

- Connect with a clinician to help manage your medications
- Find out about financial help for your medication
- Learn more about your condition and treatment through videos

We're here for you 24/7

1-855-427-4682
(TTY **711**)
specialty.optumrx.com

Sign in or register today

Guiding your health journey

Managing and living with a complex health condition is challenging. We're here for you when you need us.

Getting started

Call **1-855-427-4682** to switch.

Pharmacists and patient care coordinators are ready 24/7 to help you:

- Transfer your prescription
- Find affordable ways to get your medication
- Explain how to use the specialty pharmacy

Personalized support

We're always ready by phone to answer questions about your medication, side effects and more. You can also use the tools below:

Virtual visits – Set up a video chat with an expert in your condition. Ask questions from the privacy of your home. You can even record your session to review later or to share with your caregivers.

Video series – Watch videos from other patients with specialty conditions. Hear about their treatment and how they are doing.

Working with your pharmacist or nurse

- Tell us how your therapy is going, if you're having trouble keeping up, having side effects or forgetting to take your medication.
- We can help you find wellness programs to help you stay on track.
- If you're part of a clinical management program, follow your care plan and tell us about any new medications you're taking.

Staying on track

A few days before your next fill, we'll send you a refill reminder by email, phone or text. Call us to sign up for text messages.

Optum® Specialty Pharmacy can only fill specialty medications. Use your home delivery or retail pharmacy for your non-specialty prescriptions. You may pay less with home delivery and lower-cost options.

*Some medications for more complex conditions do not qualify for online ordering. Call 1-855-427-4682 and speak with a patient care coordinator to order those refills.

Optum

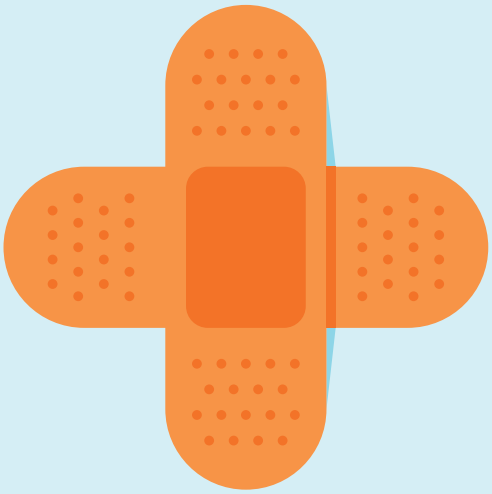
Optum Rx specializes in the delivery, clinical management and affordability of prescription medications and consumer health products. We are an Optum® company – a leading provider of integrated health services. Learn more at **optum.com**.

Optum Specialty Pharmacy is affiliated with Optum Rx, a pharmacy benefits manager. You may not be required to use Optum Specialty Pharmacy for your specialty medication. There may other pharmacies available in your network. Call the customer service number on your member ID card or visit your plan website and use the pharmacy locator to view listings. Your receipt of this communication is acknowledgment of the information provided. You may contact the customer service number on your member ID card for any questions or concerns.

Optum Rx®

Make your health a priority

Get your flu shot and other routine vaccines



Flu shots

Every year millions of people get the flu. Most people who get the flu have a mild illness. But for some, it can lead to serious health problems. The flu is caused by influenza viruses that affect the lungs, throat and nose. It can be contagious. According to the Centers for Disease Control and Prevention (CDC), getting the yearly flu vaccine is the best way to protect yourself from the flu.[1] The CDC recommends a yearly **flu vaccine** for everyone 6 months of age and older.

Routine vaccines

Vaccines help protect you from serious infectious diseases throughout your life – from infancy to early adulthood and into old age. The list of routine vaccines on page 3 are recommended by the Advisory Committee on Immunization Practices (ACIP). This is a federal committee comprised of immunization experts that is convened by the CDC. Routine vaccines are covered on most plans and can help you and your family stay healthy.

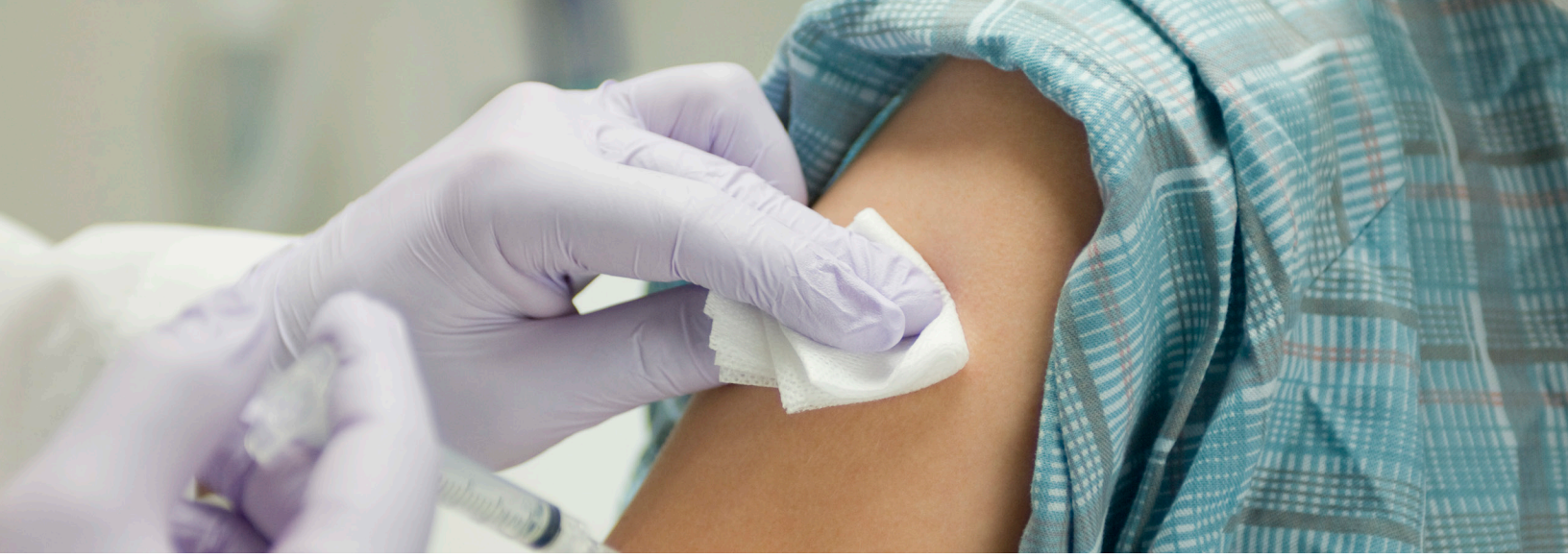
Schedule your flu shot or vaccine today

You can schedule a flu shot or a routine vaccine at a network pharmacy. Go to **OptumRx.com** and search for a retail pharmacy nearest you.

Many vaccines are available on a walk-in basis.

Show your member ID card before getting your flu shot or vaccine. Most plans cover routine vaccines at 100% when you use network pharmacies.

For more information, sign in to **OptumRx.com** or call the number on your member ID card.



Retail pharmacies

This list shows the larger retail chain pharmacies in our network, but is not the full list. For a more complete list, you can log in to **OptumRx.com** or call the number on your health plan or prescription ID card. Pharmacists give the vaccines at these locations.

- **Ahold USA** (Giant Food Stores, Giant of Maryland, Hannaford, Stop & Shop)
- **Albertsons** Acme, Carrs, Haggen, Market Street, Osco Drug, Pavilions, Safeway, Shaw's Supermarket, Randalls, Sav-On Drugs, Tom Thumb, United, Vons
- **CVS Pharmacy**
- **Four B Corporation** (Hen House, Price Chopper)
- **H-E-B Pharmacy**
- **Hy-Vee Pharmacy**
- **Kmart Pharmacy**
- **The Kroger Co.** (Baker's Pharmacy, City Market, Dillons, Fred Meyer, Fry's, Gerbes Pharmacy, Jay C Food Stores, King Soopers, Mariano's, Metro Market,Pay Less, Pick 'n Save, QFC, Ralphs, Smiths Food and Drug)
- **K-VA-T Food Stores, Inc.** (Food City)
- **Meijer Pharmacies**
- **Publix**
- **Rite Aid**
- **Thrifty White Pharmacy**
- **Tops Markets**
- **Walgreens Pharmacy** (Duane Reade, Walgreens)
- **Walmart Pharmacy**
- **Wegmans**

What vaccines do you need?

Talk to your doctor about the specific needs of you and your family. Here is a list of flu shots and CDC-recommended routine vaccines.

Age restrictions or limitations may apply. Check with your network pharmacy for requirements.

Flu shots

Flu (Influenza)[2]

Afluria Quad	Flublok Quad	FluMist Quad
Fluad Quad	Flucelvax Quad	Fluzone High-Dose Quad
Fluarix Quad	Flulaval Quad	Fluzone Quad

Other vaccines[2]

COVID-19 – Age edits per ACIP recommendations apply.	
Hepatitis A	Havrix, Vaqta
Hepatitis B	Engerix-B, Heplisav-B, PreHevbrio, Recombivax HB
Human Papilloma Virus (HPV) – Vaccine prevents HPV-related cancers (ages 9-26 years)	Gardisil 9
Measles, Mumps, Rubella	M-M-R II
Meningococcal – Vaccine prevents meningitis Groups A, C, Y and W-135	Menactra, Menquadfi, Menveo
Meningococcal – Vaccine prevents meningitis Group B	Bexsero, Trumenba
Pneumococcal – Vaccine prevents pneumonia	Prevnar 13, Pneumovax 23, Vaxneuvance, Prevnar 20
Tdap – Vaccine prevents tetanus, diptheria, pertussis	Adacel, Boostrix
Td – Vaccine prevents tetanus and diptheria	TDVax, Tenivac
Varicella – Vaccine prevents chicken pox	Varivax
Zoster – Vaccine prevents shingles	Shingrix

Please note this list is subject to change. Ask your employer or check your plan documents for your plan's specific details.

Not all vaccines on this list are available at all network pharmacies. Contact your local network pharmacy to confirm which vaccines they offer.

[1] Centers for Disease Control and Prevention. Influenza. cdc.gov/flu. Last reviewed November 18, 2021. Accessed July 29, 2022.

[2] 2023 Recommended vaccinations for children and adults. cdc.gov/vaccines. Accessed May 17, 2023.

CharterLIFE™
Believe Build Benefit

Kaiser

High HMO

Disclosure Form Part One

230290 CharterLIFE
Home Region: Southern California
1/1/24 through 12/31/24

Principal benefits for Kaiser Permanente Traditional HMO Plan

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	$1,500	$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Plan Provider Office Visits	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$10 per visit
Most Physician Specialist Visits	$10 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Scheduled prenatal care exams	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	$10 per visit
Most physical, occupational, and speech therapy	$10 per visit

Telehealth Visits	You Pay
Primary Care Visits and Non-Physician Specialist Visits by interactive video	No charge
Physician Specialist Visits by interactive video	No charge
Primary Care Visits and Non-Physician Specialist Visits by telephone	No charge
Physician Specialist Visits by telephone	No charge

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$10 per procedure
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge

Hospital Inpatient Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge

Emergency Services	You Pay
Emergency department visits	$150 per visit

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see “Hospital Inpatient Services” for inpatient Cost Share)

Ambulance Services	You Pay
Ambulance Services	No charge

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy	$10 for up to a 30-day supply
Most generic (Tier 1) refills through our mail-order service	$20 for up to a 100-day supply
Most brand-name items (Tier 2) at a Plan Pharmacy	$25 for up to a 30-day supply
Most brand-name (Tier 2) refills through our mail-order service	$50 for up to a 100-day supply
Most specialty items (Tier 4) at a Plan Pharmacy	20% Coinsurance (not to exceed $150) for up to a 30-day supply

Durable Medical Equipment (DME)	You Pay
DME items as described in the *EOC*	No charge

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	No charge

(continues)

Mental Health Services	You Pay
Individual outpatient mental health evaluation and treatment	$10 per visit
Group outpatient mental health treatment	$5 per visit
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment	$10 per visit
Group outpatient substance use disorder treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the *EOC*	No charge
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC*	50% Coinsurance
Assisted reproductive technology (“ART”) Services	Not covered
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

CharterLIFE™
Believe Build Benefit

Kaiser

Low HMO

Disclosure Form Part One

230290 CharterLIFE
Home Region: Southern California
1/1/24 through 12/31/24

Principal benefits for Kaiser Permanente Traditional HMO Plan

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	$1,500	$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Plan Provider Office Visits	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$20 per visit
Most Physician Specialist Visits	$20 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Scheduled prenatal care exams	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	$20 per visit
Most physical, occupational, and speech therapy	$20 per visit

Telehealth Visits	You Pay
Primary Care Visits and Non-Physician Specialist Visits by interactive video	No charge
Physician Specialist Visits by interactive video	No charge
Primary Care Visits and Non-Physician Specialist Visits by telephone	No charge
Physician Specialist Visits by telephone	No charge

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$20 per procedure
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge

Hospital Inpatient Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$250 per admission

Emergency Services	You Pay
Emergency department visits	$150 per visit

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see “Hospital Inpatient Services” for inpatient Cost Share)

Ambulance Services	You Pay
Ambulance Services	$50 per trip

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy	$15 for up to a 30-day supply
Most generic (Tier 1) refills through our mail-order service	$30 for up to a 100-day supply
Most brand-name items (Tier 2) at a Plan Pharmacy	$30 for up to a 30-day supply
Most brand-name (Tier 2) refills through our mail-order service	$60 for up to a 100-day supply
Most specialty items (Tier 4) at a Plan Pharmacy	20% Coinsurance (not to exceed $200) for up to a 30-day supply

Durable Medical Equipment (DME)	You Pay
DME items as described in the *EOC*	No charge

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	$250 per admission

(continues)

Mental Health Services	You Pay
Individual outpatient mental health evaluation and treatment	$20 per visit
Group outpatient mental health treatment	$10 per visit
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	$250 per admission
Individual outpatient substance use disorder evaluation and treatment	$20 per visit
Group outpatient substance use disorder treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the *EOC*	No charge
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC*	50% Coinsurance
Assisted reproductive technology (“ART”) Services	Not covered
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

CharterLIFE™
Believe Build Benefit

Kaiser

$1500 HMO

Disclosure Form Part One

230290 CharterLIFE
Home Region: Southern California
1/1/24 through 12/31/24

Principal benefits for Kaiser Permanente Deductible HMO Plan

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductibles apply to the Plan Out-of-Pocket Maximum amounts listed below.

Amounts Per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$4,000	$4,000	$8,000
Plan Deductible	$1,500	$1,500	$3,000
Drug Deductible	None	None	None

Plan Provider Office Visits	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$20 per visit (Plan Deductible doesn't apply)
Most Physician Specialist Visits	$20 per visit (Plan Deductible doesn't apply)
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Scheduled prenatal care exams	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist	No charge (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	$20 per visit (Plan Deductible doesn't apply)
Most physical, occupational, and speech therapy	$20 per visit (Plan Deductible doesn't apply)

Telehealth Visits	**You Pay**
Primary Care Visits and Non-Physician Specialist Visits by interactive video	No charge (Plan Deductible doesn't apply)
Physician Specialist Visits by interactive video	No charge (Plan Deductible doesn't apply)
Primary Care Visits and Non-Physician Specialist Visits by telephone	No charge (Plan Deductible doesn't apply)
Physician Specialist Visits by telephone	No charge (Plan Deductible doesn't apply)

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	20% Coinsurance after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter (Plan Deductible doesn't apply)
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	20% Coinsurance up to a maximum of $50 per procedure (Plan Deductible doesn't apply)

Hospital Inpatient Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	20% Coinsurance after Plan Deductible

Emergency Services	**You Pay**
Emergency department visits	20% Coinsurance after Plan Deductible

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share)

Ambulance Services	**You Pay**
Ambulance Services	$150 per trip (Plan Deductible doesn't apply)

Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy	$10 for up to a 30-day supply (Plan Deductible doesn't apply)
Most generic (Tier 1) refills through our mail-order service	$20 for up to a 100-day supply (Plan Deductible doesn't apply)

(continues)

Prescription Drug Coverage	**You Pay**
Most brand-name items (Tier 2) at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)
Most brand-name (Tier 2) refills through our mail-order service	$60 for up to a 100-day supply (Plan Deductible doesn't apply)
Most specialty items (Tier 4) at a Plan Pharmacy	20% Coinsurance (not to exceed $150) for up to a 30-day supply (Plan Deductible doesn't apply)
Durable Medical Equipment (DME)	**You Pay**
DME items as described in the *EOC*	20% Coinsurance (Plan Deductible doesn't apply)
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	20% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	$20 per visit (Plan Deductible doesn't apply)
Group outpatient mental health treatment	$10 per visit (Plan Deductible doesn't apply)
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	20% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	$20 per visit (Plan Deductible doesn't apply)
Group outpatient substance use disorder treatment	$5 per visit (Plan Deductible doesn't apply)
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge (Plan Deductible doesn't apply)
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	20% Coinsurance (Plan Deductible doesn't apply)
Prosthetic and orthotic devices as described in the *EOC*	No charge (Plan Deductible doesn't apply)
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC*	50% Coinsurance (Plan Deductible doesn't apply)
Assisted reproductive technology ("ART") Services	Not covered
Hospice care	No charge (Plan Deductible doesn't apply)

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

CharterLIFE™
Believe Build Benefit

Kaiser

HRA

$3000

Disclosure Form Part One

230290 CharterLIFE
Home Region: Southern California
1/1/24 through 12/31/24

Principal benefits for Kaiser Permanente Deductible HMO Plan

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductibles apply to the Plan Out-of-Pocket Maximum amounts listed below.

Amounts Per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$6,000	$6,000	$12,000
Plan Deductible	$3,000	$3,000	$6,000
Drug Deductible	None	None	None

Plan Provider Office Visits	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	20% Coinsurance after Plan Deductible
Most Physician Specialist Visits	20% Coinsurance after Plan Deductible
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Scheduled prenatal care exams	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist	No charge (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	20% Coinsurance after Plan Deductible
Most physical, occupational, and speech therapy	20% Coinsurance after Plan Deductible

Telehealth Visits	**You Pay**
Primary Care Visits and Non-Physician Specialist Visits by interactive video	No charge (Plan Deductible doesn't apply)
Physician Specialist Visits by interactive video	No charge (Plan Deductible doesn't apply)
Primary Care Visits and Non-Physician Specialist Visits by telephone	No charge (Plan Deductible doesn't apply)
Physician Specialist Visits by telephone	No charge (Plan Deductible doesn't apply)

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	20% Coinsurance after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	20% Coinsurance after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Plan Deductible doesn't apply)

Hospital Inpatient Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	20% Coinsurance after Plan Deductible

Emergency Services	**You Pay**
Emergency department visits	20% Coinsurance after Plan Deductible

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share)

Ambulance Services	**You Pay**
Ambulance Services	20% Coinsurance after Plan Deductible

Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy or through our mail-order service	20% Coinsurance (not to exceed $50) for up to a 100-day supply (Plan Deductible doesn't apply)
Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service	20% Coinsurance (not to exceed $100) for up to a 100-day supply (Plan Deductible doesn't apply)
Most specialty items (Tier 4) at a Plan Pharmacy	20% Coinsurance (not to exceed $200) for up to a 30-day supply (Plan Deductible doesn't apply)

(continues)

Durable Medical Equipment (DME)	**You Pay**
DME items as described in the *EOC*	20% Coinsurance (Plan Deductible doesn't apply)
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	20% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	20% Coinsurance after Plan Deductible
Group outpatient mental health treatment	20% Coinsurance after Plan Deductible
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	20% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	20% Coinsurance after Plan Deductible
Group outpatient substance use disorder treatment	20% Coinsurance after Plan Deductible
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge (Plan Deductible doesn't apply)
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	20% Coinsurance after Plan Deductible
Prosthetic and orthotic devices as described in the *EOC*	No charge (Plan Deductible doesn't apply)
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC*	50% Coinsurance (Plan Deductible doesn't apply)
Assisted reproductive technology ("ART") Services	Not covered
Hospice care	No charge (Plan Deductible doesn't apply)

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Provided by American Specialty Health Plans of California, Inc. (ASH Plans)

Your Kaiser Permanente **CHIROPRACTIC benefits**

When you need chiropractic care, follow these simple steps:

1. Find an ASH Participating Provider near you:
   - Go to **ashlink.com/ash/kp**, or
   - Call **1-800-678-9133** (TTY **711**), Monday through Friday, from 5 a.m. to 6 p.m. Pacific time
2. Schedule an appointment.
3. Pay for your office visit when you arrive for your appointment.

(See the reverse for more details.)

American Specialty Health Plans of California

KAISER PERMANENTE®

YOUR KAISER PERMANENTE

CHIROPRACTIC BENEFIT

Office Visits	Cost Sharing and Visit Limits
Covered Services are limited to Medically Necessary Chiropractic Services authorized and provided by ASH Participating Providers except for the initial examination, Emergency Chiropractic Services, Urgent Chiropractic Services, and Services that are not available from ASH Participating Providers or other licensed providers with which ASH contracts to provide covered care. You can obtain an initial examination from any ASH Participating Provider without a referral from a Kaiser Permanente Plan Physician. Each office visit counts toward any visit limit, if applicable.	**Office visit cost share:** $15 copayment per visit (if your *Amendment* is paired with an HDHP HMO evidence of coverage, this cost share is subject to the Plan Deductible described in your *EOC*) **Office visit limit:** 30 visits per year **Chiropractic supports and appliances:** If the amount of the appliance in the ASH Plans fee schedule exceeds $50, you will pay the amount in excess of $50. Covered chiropractic appliances are limited to: elbow supports, back supports, cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces and supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units, ankle braces, knee braces, rib supports, and wrist braces.

X-rays and laboratory tests: Medically Necessary X-rays and laboratory tests are covered at no charge when prescribed as part of covered chiropractic care and an ASH Participating Provider provides the Services or refers you to another licensed provider with which ASH contracts for the Services. If your *Amendment* is paired with an HDHP HMO evidence of coverage, this cost share is subject to the Plan Deductible described in your *EOC*.

ASH Participating Providers

ASH Plans contracts with ASH Participating Providers and other licensed providers to provide covered Chiropractic Services. You must receive these services from an ASH Participating Provider or another licensed provider with which ASH contracts, except for Emergency Chiropractic Services, Urgent Chiropractic Services, and Services that are not available from contracted providers that are authorized in advance by ASH Plans. The list of ASH Participating Providers is available on the ASH Plans website at **ashlink.com/ash/kaisercamedicare** for Kaiser Permanente Senior Advantage members, or **ashlink.com/ash/kp** for all other members, or from the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY **711**). The list of ASH Participating Providers is subject to change at any time without notice.

How to obtain services

To obtain covered Services, call an ASH Participating Provider to schedule an initial examination. If additional Services are required, verification that the Services are Medically Necessary may be required. Your ASH Participating Provider will request any medical necessity determinations. An ASH Plans clinician in the same or similar specialty as the provider of Services under review will decide whether the Services are or were Medically Necessary. ASH Plans will disclose to you, upon request, the written criteria it uses to make the decision to authorize, modify, delay, or deny a request for authorization. If you have questions or concerns, please contact the ASH Plans Customer Service Department.

Second Opinions

You may request a second opinion in regard to covered Services by contacting another ASH Participating Provider. An ASH Participating Provider may also request a second opinion in regard to covered Services by referring you to another ASH Participating Provider in the same or similar specialty.

Your costs

When you receive covered Chiropractic Services, you must pay the cost share described below. The cost share does not apply toward the Plan Deductible or Plan Out-of-Pocket Maximum described in your Health Plan *Evidence of Coverage* ("*EOC*"), unless your *Chiropractic Services Amendment* ("*Amendment*") is amending an HSA-Qualified High Deductible Health Plan (HDHP) HMO plan evidence of coverage. If your *Amendment* is paired with an HDHP HMO evidence of coverage, the cost share you pay for covered Services is subject to the Plan Deductible and Plan Out-of-Pocket Maximum described in your *EOC*.

Emergency and Urgent Chiropractic Services

We cover Emergency Chiropractic Services and Urgent Chiropractic Services provided by both ASH Participating Providers and Non–Participating Providers. We do not cover follow-up or continuing care from a Non–Participating Provider unless ASH Plans has authorized the services in advance. Also, we do not cover services from a Non–Participating Provider that ASH Plans determines are not Emergency Chiropractic Services or Urgent Chiropractic Services.

Getting Assistance

If you have a question or concern regarding the Services you received from an ASH Participating Provider or another licensed provider with which ASH Plans contracts, you may call the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY **711**), weekdays from 5 a.m. to 6 p.m. Pacific time.

Grievances

You can file a grievance with Kaiser Permanente regarding any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied with Services you received. You may submit your grievance orally or in writing to Kaiser Permanente as described in your Health Plan *EOC*.

Exclusions

- Services provided by a chiropractor that are not within the scope of licensure for a chiropractor licensed in California
- Adjunctive therapy not associated with spinal, muscle, or joint manipulations
- Air conditioners, air purifiers, therapeutic mattresses, chiropractic appliances, durable medical equipment, supplies, devices, appliances, and any other item except those listed as covered in your *Amendment*
- Services for asthma or addiction, such as nicotine addiction
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Thermography
- Experimental or investigational Services
- CT scans, MRIs, PET scans, bone scans, nuclear medicine, and any other type of diagnostic imaging or radiology other than X-rays covered under the "Covered Services" section of your *Amendment*
- Ambulance and other transportation
- Education programs, non-medical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing
- Services for pre-employment physicals or vocational rehabilitation
- Drugs and medicines, including non-legend or proprietary drugs and medicines
- Services you receive outside the state of California except for Emergency Chiropractic Services and Urgent Chiropractic Services
- Hospital services, anesthesia, manipulation under anesthesia, and related services
- Dietary and nutritional supplements, such as vitamins, minerals, herbs, herbal products, injectable supplements, and similar products
- Massage therapy
- Maintenance care (services provided to members whose treatment records indicate that they have reached maximum therapeutic benefit)

Definitions

ASH Participating Provider: A chiropractor who is licensed to provide chiropractic services in California and who has a contract with ASH Plans to provide Medically Necessary Chiropractic Services to you.

ASH Plans: American Specialty Health Plans of California, Inc., a California corporation.

Chiropractic Services: Chiropractic services include spinal and extremity manipulation and adjunctive therapies such as ultrasound, therapeutic exercise, or electrical muscle stimulation, when provided during the same course of treatment and in conjunction with chiropractic manipulative services, and other services provided or prescribed by a chiropractor (including laboratory tests, X-rays, and chiropractic supports and appliances) for the treatment of your Musculoskeletal and Related Disorder.

Emergency Chiropractic Services: Covered Chiropractic Services provided for the treatment of a Musculoskeletal and Related Disorder which manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could expect the absence of immediate Chiropractic Services to result in serious jeopardy to your health or body functions or organs.

Medically Necessary: A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Musculoskeletal and Related Disorders: Conditions with signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the muscle or skeletal systems (muscles, tendons, fascia, nerves, ligaments/capsules, discs, and synovial structures), and related manifestations or conditions.

Non-Participating Provider: A provider other than an ASH Participating Provider.

Services: Health care services or items.

Urgent Chiropractic Services: Chiropractic Services that meet all of the following requirements:

- They are necessary to prevent serious deterioration of your health, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy.
- They cannot be delayed until you return to the Service Area.

This is a summary and is intended to highlight only the most frequently asked questions about the chiropractic benefit, including cost share. Please refer to the *Amendment* for a detailed description of the chiropractic coverage.

Language Assistance Services

English: Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, materials translated into your language, or in alternative formats. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

Arabic: خدمات الترجمة الفورية متوفرة لك مجانًا على مدار الساعة كافة أيام الأسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائق للغتك أو لصيغ أخرى. ما عليك سوى الاتصال بنا على الرقم **1-800-464-4000** على مدار الساعة كافة أيام الأسبوع (مغلق أيام العطلات). لمستخدمي خدمة الهاتف النصي يرجي الاتصال على الرقم (**711**).

Armenian: Ձեզ կարող է անվճար օգնություն տրամադրվել լեզվի հարցում՝ օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Պարզապես զանգահարեք մեզ՝ **1-800-464-4000** հեռախոսահամարով՝ օրը 24 ժամ՝ շաբաթը 7 օր (տոն օրերին փակ է): TTY-ից օգտվողները պետք է զանգահարեն **711**:

Chinese: 您每週 7 天，每天 24 小時均可獲得免費語言協助。您可以申請口譯服務、要求將資料翻譯成您所用語言或轉換為其他格式。我們每週 7 天，每天 24 小時均歡迎您打電話 **1-800-757-7585** 前來聯絡（節假日 休息）。聽障及語障專線 (TTY) 使用者請撥 **711**。

Farsi: خدمات زبانی در 24 ساعت شبانروز و 7 روز هفته بدون اخذ هزینه در اختیار شما است. شما می توانید برای خدمات مترجم شفاهی، ترجمه جزوات به زبان شما و یا به صورتهای دیگر درخواست کنید. کافیست در 24 ساعت شبانروز و 7 روز هفته (به استثنای روزهای تعطیل) با ما به شماره **1-800-464-4000** تماس بگیرید. کاربران TTY با شماره **711** تماس بگیرند.

Hindi: बिना किसी लागत के दुभाषिया सेवाएँ, दिन के 24 घंटे, सप्ताह के सातों दिन उपलब्ध हैं। आप एक दुभाषिये की सेवाओं के लिए, बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए, या वैकल्पिक प्रारूपों के लिए अनुरोध कर सकते हैं। बस केवल हमें **1-800-464-4000** पर, दिन के 24 घंटे, सप्ताह के सातों दिन (छुट्टियों वाले दिन बंद रहता है) कॉल करें। TTY उपयोगकर्ता **711** पर कॉल करें।

Hmong: Muajkwc pab txhais lus pub dawb rau koj, 24 teev ib hnub twg, 7 hnub ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntaub ntawv txhais ua koj hom lus, los yog ua lwm hom.Tsuas hu rau **1-800-464-4000**, 24 teev ib hnub twg, 7 hnub ib lim tiam twg (cov hnub caiv kaw). Cov neeg siv TTY hu **711**.

Japanese: 当院では、言語支援を無料で、年中無休、終日ご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは資料を別の書式でも依頼できます。お気軽に **1-800-464-4000** までお電話ください（祭日を除き年中無休）。TTY ユーザーは **711** にお電話ください。

Khmer: ជំនួយភាសា គឺមានឥតអស់ថ្លៃដល់អ្នកទ្បើយ 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ សំភារៈដែលបានបកប្រែទៅជាភាសាខ្មែរ ឬជាទំរង់ផ្សឹងទៀត។ គ្រាន់តែទូរសំព្ទមកយើង តាមលេខ **1-800-464-4000** បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ (បិទថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ **711**។

Korean: 요일 및 시간에 관계없이 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스, 귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 요일 및 시간에 관계없이 **1-800-464-4000**번으로 전화하십시오 (공휴일 휴무). TTY 사용자 번호 **711**.

Laotian: ການຊ່ວຍເຫຼືອດ້ານພາສາມີໃຫ້ໂດຍບໍ່ເສັງຄ່ຳ ແກ່ທ່ານ, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ. ທ່ານ ສາມາດຮ້ອງຂໍຮັບບໍລິການນາຍພາສາ, ໃຫ້ແປເອກະ ສານເປັນພາສາຂອງທ່ານ, ຫຼື ໃນຮູບແບບອື່ນ. ພຽງ ແຕ່ໂທຣຫາພວກເຮົາທີ່ **1-800-464-4000**, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ (ປິດວັນພັກຕ່າງໆ). ຜູ້ໃຊ້ສາຍ TTY ໂທຣ **711**.

Navajo: Saad bee áká'a'ayeed náhóló t'áá jiik'é, naadiin doo bibąą' dį́į' ahéé'iikeed tsosts'id yiskąąjį́ damoo ná'ádleehjį́. Atah halne'é áká'adoolwołígíí jóki, t'áadoo le'é t'áá hóhazaadjį́ hadilyąą'go, éí doodaii' nááná lá ał'ąą ádaat'ehígíí bee hádadilyaa'go. Kojį́ hodiilnih **1-800-464-4000**, naadiin doo bibąą' dį́į' ahéé'iikeed tsosts'id yiskąąjį́ damoo ná'ádleehjį́ (Dahodiyin biniiyé e'e'aahgo éí da'deelkaal). TTY chodeeyoolínígíí kojį́ hodiilnih **711**.

Punjabi: ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ, ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਮਦਦ ਲਈ, ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਲਈ, ਜਾਂ ਕਿਸੇ ਵੱਖ ਫਾਰਮੈਟ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਬਸ ਸਿਰਫ਼ ਸਾਨੂੰ **1-800-464-4000** ਤੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਫ਼ੋਨ ਕਰੋ। TTY ਦਾ ਉਪਯੋਗ ਕਰਨ ਵਾਲੇ **711** 'ਤੇ ਫ਼ੋਨ ਕਰਨ।

Russian: Мы бесплатно обеспечиваем Вас услугами перевода 24 часа в сутки, 7 дней в неделю. Вы можете воспользоваться помощью устного переводчика, запросить перевод материалов на свой язык или запросить их в одном из альтернативных форматов. Просто позвоните нам по телефону **1-800-464-4000**, который доступен 24 часа в сутки, 7 дней в неделю (кроме праздничных дней). Пользователи линии TTY могут звонить по номеру **711**.

Spanish: Contamos con asistencia de idiomas sin costo alguno para usted 24 horas al día, 7 días a la semana. Puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o en formatos alternativos. Solo llame al **1-800-788-0616**, 24 horas al día, 7 días a la semana (cerrado los días festivos). Los usuarios de TTY, deben llamar al **711**.

Tagalog: May magagamit na tulong sa wika nang wala kang babayaran, 24 na oras bawat araw, 7 araw bawat linggo. Maaari kang humingi ng mga serbisyo ng tagasalin sa wika, mga babasahin na isinalin sa iyong wika o sa mga alternatibong format. Tawagan lamang kami sa **1-800-464-4000**, 24 na oras bawat araw, 7 araw bawat linggo (sarado sa mga pista opisyal). Ang mga gumagamit ng TTY ay maaaring tumawag sa **711**.

Thai: **เรามีบริการล่ามฟรีสำหรับคุณตลอด** 24 **ชั่วโมง ทุกวันตลอดชั่วโมงทำการของเราคุณสามารถขอให้ล่ามช่วยตอบคำถามของคุณที่เกี่ยวกับความคุ้มครองการดูแลสุขภาพของเราและคุณยังสามารถขอให้มีการแปลเอกสารเป็นภาษาที่คุณใช้ได้โดยไม่มีการคิดค่าบริการเพียงโทรหาเราที่หมายเลข 1-800-464-4000 ตลอด** 24 **ชั่วโมงทุกวัน (ปิดให้บริการในวันหยุดราชการ) ผู้ใช้** TTY **โปรดโทรไปที่ 711**

Vietnamese: Dịch vụ thông dịch được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, tài liệu phiên dịch ra ngôn ngữ của quý vị hoặc tài liệu bằng nhiều hình thức khác. Quý vị chỉ cần gọi cho chúng tôi tại số **1-800-464-4000**, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ). Người dùng TTY xin gọi **711**.

CharterLIFE™
Believe Build Benefit

Delta Dental PPO

DELTA DENTAL

Keep Smiling

Delta Dental PPO™

Save with PPO

Visit a dentist in the PPO[1] network to maximize your savings.[2] These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.[3] Find a PPO dentist at **deltadentalins.com**.

Set up an online account

Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at **deltadentalins.com**.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need your information. Prefer to have an ID card? Simply log in to your account to view or print your card.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim — we'll handle the rest.

Understand transition of care

Generally, multi-stage procedures are covered under your current plan only if treatment began after your plan's effective date of coverage.[4] Log in to your online account to find this date.

Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care[5], you can save as much as 50% on LASIK procedures and more than 60% on hearing aids. To take advantage of these discounts, call QualSight at **855-248-2020** and Amplifon at **888-779-1429**.

Save with a PPO dentist

PPO

NON-PPO

[1] In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

[2] You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

[3] You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

[4] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

[5] Vision corrective services and Amplifon's hearing health care services are not insured benefits. Delta Dental makes the vision corrective services program and hearing health care services program available to you to provide access to the preferred pricing for LASIK surgery and for hearing aids and other hearing health services.

HL_PPO #129455W (rev. 10/20)

Plan Benefit Highlights for: CharterLIFE (PPO 2000 Plan)
Group No: 17072

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).			
Deductibles	$50 per person / $150 per family each calendar year			
Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	Yes			
Maximums	$2,000 per person each calendar year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Services None	Major Services None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100 %	100 %
Basic Services Fillings	80 %	60 %
Endodontics (root canals) Covered Under Basic Services	80 %	60 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	60 %
Oral Surgery Covered Under Basic Services	80 %	60 %
Major Services Crowns, inlays, onlays and cast restorations	50 %	40 %
Prosthodontics Bridges, dentures and implants	50 %	40 %
Orthodontic Benefits Adults and dependent children	50 %	50 %
Orthodontic Maximums	$2,500 Lifetime	$2,500 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of California
560 Mission St., Suite 1300
San Francisco, CA 94105

Customer Service
888-335-8227

Claims Address
P.O. Box 997330
Sacramento, CA 95899-7330

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

DELTA DENTAL

Keep Smiling

Delta Dental PPO™

Save with PPO

Visit a dentist in the PPO[1] network to maximize your savings.[2] These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.[3] Find a PPO dentist at **deltadentalins.com**.

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Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at **deltadentalins.com**.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need your information. Prefer to have an ID card? Simply log in to your account to view or print your card.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim — we'll handle the rest.

Understand transition of care

Generally, multi-stage procedures are covered under your current plan only if treatment began after your plan's effective date of coverage.[4] Log in to your online account to find this date.

Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care[5], you can save as much as 50% on LASIK procedures and more than 60% on hearing aids. To take advantage of these discounts, call QualSight at **855-248-2020** and Amplifon at **888-779-1429**.

Save with a PPO dentist

PPO

NON-PPO

[1] In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

[2] You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

[3] You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

[4] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

[5] Vision corrective services and Amplifon's hearing health care services are not insured benefits. Delta Dental makes the vision corrective services program and hearing health care services program available to you to provide access to the preferred pricing for LASIK surgery and for hearing aids and other hearing health services.

HL_PPO #129455W (rev. 10/20)

Plan Benefit Highlights for: CharterLIFE
(PPO 1000 Plan)
Group No: 17072

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).			
Deductibles	$50 per person / $150 per family each calendar year			
Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	Yes			
Maximums	$1,000 per person each calendar year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Services None	Major Services None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100 %	100 %
Basic Services Fillings	80 %	60 %
Endodontics (root canals) Covered Under Basic Services	80 %	60 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	60 %
Oral Surgery Covered Under Basic Services	80 %	60 %
Major Services Crowns, inlays, onlays and cast restorations	50 %	40 %
Prosthodontics Bridges, dentures and implants	50 %	40 %
Orthodontic Benefits Dependent children to age 19	50 %	50 %
Orthodontic Maximums	$1,500 Lifetime	$1,500 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of California
560 Mission St., Suite 1300
San Francisco, CA 94105

Customer Service
888-335-8227

Claims Address
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deltadentalins.com

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CharterLIFE™
Believe Build Benefit

Delta Dental

DHMO

DeltaCare® USA – provided by Delta Dental of California

We'll do **whatever it takes and then some.**

Find a DeltaCare USA dentist

Select from among the many conveniently located DeltaCare USA contracted general dentists. To find the most current listing of DeltaCare USA dental offices you can:

Visit our website at **deltadentalins.com/enrollees**. Under Find a dentist, select DeltaCare USA as your network.

Or call Customer Service at **800-422-4234** for help in finding a DeltaCare USA dentist.

Welcome to DeltaCare USA — quality, convenience, predictable costs

DeltaCare USA (administered by Delta Dental Insurance Company) provides you and your family with quality dental benefits at an affordable cost. The DeltaCare USA program is designed to encourage you and your family to visit the dentist regularly to maintain your dental health.

When you enroll, you select a contract dentist to provide services. The DeltaCare USA network consists of private practice dental facilities that have been carefully screened for quality.

Enroll in DeltaCare USA and you'll enjoy these features:

Quality

- Extensive benefits for you and your family
- No restrictions on pre-existing conditions, except for work in progress
- Large, stable network of dentists, so you can enjoy a long-term relationship with your dentist

Convenience

- No claim forms to complete
- Easy access to specialty care
- Expanded business hours for toll-free customer service, from 5 a.m. to 6 p.m., Pacific time

Predictable costs

- No deductibles
- Out-of-pocket costs are clearly defined
- Out-of-area dental emergency coverage up to $100 per emergency
- No annual or lifetime dollar maximums

DELTA DENTAL®

Administered by Delta Dental Insurance Company

What if I have questions about my DeltaCare USA Program?

Eligibility for you and your family

If you meet your group's eligibility requirements for dental coverage, you can enroll in the DeltaCare USA program. You may also enroll eligible dependents. Contact your benefits administrator if you have any questions.

Easy enrollment

Simply complete the enrollment process as directed by your benefits administrator. Be sure to indicate a dentist (from the list of contract dental facilities) for both yourself and your eligible dependents. Include the name of your group.

How your DeltaCare USA program works

Your selected contract dentist will take care of your dental care needs. If you require treatment from a specialist, your contract dentist will handle the referral for you.

After you have enrolled, you will receive a Delta Dental membership packet that includes an identification card and an Evidence of Coverage booklet that fully describes the benefits of your dental program. Also included in this packet are the name, address and phone number of your contract dentist. Simply call the dental facility to make an appointment.

Under the DeltaCare USA program, many services are covered at no cost, while others have copayments (amount you pay your contract dentist) for certain benefits. See the "Description of Benefits and Copayments" for a list of your benefits.

Please note: Dental services that are not performed by your selected contract dentist, or are not covered under provisions for emergency care below, must be preauthorized by Delta Dental to be covered by your DeltaCare USA program.

Provisions for emergency care

Under your DeltaCare USA program, you and your eligible dependents are covered for out-of-network dental emergencies. Your program pays up to $100 for out-of-network emergency dental expenses per emergency for each enrollee.

My dentist is a Delta Dental dentist but is not on the list of DeltaCare USA dentists. Can I still receive treatment from this dentist?

You must receive treatment from your selected DeltaCare USA contract dentist. Please note that Delta Dental dentists are not necessarily DeltaCare USA dentists. With more than 3,800 general and specialist dentists, the DeltaCare USA network is one of the largest dental networks in California.

Do my family members receive treatment from the same DeltaCare USA contract dentist?

You and your eligible dependents may receive care from the same contract dentist, or if you prefer, you may collectively select up to a maximum of three individual contract dental facilities.

Can I change my contract dentist?

You may change contract dentists by notifying us either by phone or in writing, or by visiting our website (deltadentalins.com). If you contact us by the 21st of the month, the change will become effective the first of the following month.

Can I have my teeth whitened under the DeltaCare USA program?

External bleaching is a benefit under your program. See the "Description of Benefits and Copayments" and talk to your contract dentist about your options.

Highlights of your DeltaCare USA Program

Does my DeltaCare USA program cover tooth-colored fillings and crowns?

Porcelain and other tooth-colored materials are included as a benefit under your program. The copayment shows you what your out of pocket cost will be.

How long does it take to get an appointment with a DeltaCare USA dentist?

Two to four weeks is a reasonable amount of time to wait for a routine, non-urgent appointment. If you require a specific time, you may have to wait longer. Most DeltaCare USA dentists are in private group practices, which means greater appointment availability and extended office hours.

Are pre-existing dental conditions and work in progress covered?

Treatment for pre-existing conditions, such as extracted teeth, is covered under the DeltaCare USA program. However, benefits are not provided for any dental treatment started before joining the program (that is, work in progress, such as preparations for crowns, root canals and impressions for dentures). Orthodontic treatment in progress may be covered for new DeltaCare USA enrollees. See the "Limitations and Exclusions of Benefits."

How does the DeltaCare USA program encourage preventive care?

Your DeltaCare USA program is designed to encourage regular visits to the dentist by having no copayments (fees you pay to the contract dentist) on most diagnostic and preventive benefits. See the enclosed "Description of Benefits and Copayments."

Does my DeltaCare USA program cover specialists' services?

Your contract dentist will coordinate your specialty care needs for oral surgery, endodontics, periodontics or pediatric dentistry with an approved contract specialist. If there is no contract specialist within your service area, a referral to an out-of-network specialist will be authorized at no extra cost, other than the applicable copayment. If you or your dependent is assigned to a dental school clinic for specialty services, those services may be provided by a dentist, a dental student, a clinician or a dental instructor.

What if I have questions about my DeltaCare USA program?

Call Delta Dental Customer Service at 800-422-4234. We have multilingual representatives available from 5 a.m. to 6 p.m. Pacific time, Monday through Friday. Our Customer Service representatives can answer benefits questions, as well as arrange facility transfers and urgent care referrals.

Our Customer Service representatives have worked in dental facilities and can answer benefits questions, as well as arrange facility transfers and urgent care referrals.

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as CDT-2016 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *limited to children age 3 to 19, 1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *limited to children age 3 to 19, 1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *limited to children age 3 to 19, 1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	No Cost
D1000-D1999	**II. PREVENTIVE**	
D1110	Prophylaxis *cleaning* - adult - *1 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost

D1208	Topical application of fluoride - excluding varnish - *child to age 19; 1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$10.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$10.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$10.00
D1354	Interim caries arresting medicament application - *child to age 19; 1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral	$35.00
D1515	Space maintainer - fixed - bilateral	$35.00
D1520	Space maintainer - removable - unilateral	$35.00
D1525	Space maintainer - removable - bilateral	$35.00
D1550	Re-cement or re-bond space maintainer	No Cost
D1555	Removal of fixed space maintainer	No Cost

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional $100.00 per crown, beyond the 6th unit.
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

D2140	Amalgam - one surface, primary or permanent	$5.00
D2150	Amalgam - two surfaces, primary or permanent	$10.00
D2160	Amalgam - three surfaces, primary or permanent	$15.00
D2161	Amalgam - four or more surfaces, primary or permanent	$20.00
D2330	Resin-based composite - one surface, anterior	$22.00
D2331	Resin-based composite - two surfaces, anterior	$26.00
D2332	Resin-based composite - three surfaces, anterior	$28.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$40.00
D2390	Resin-based composite crown, anterior	$50.00
D2391	Resin-based composite - one surface, posterior	$65.00
D2392	Resin-based composite - two surfaces, posterior	$75.00
D2393	Resin-based composite - three surfaces, posterior	$85.00
D2394	Resin-based composite - four or more surfaces, posterior	$95.00
D2510	Inlay - metallic - one surface	$45.00
D2520	Inlay - metallic - two surfaces	$50.00
D2530	Inlay - metallic - three or more surfaces	$55.00
D2542	Onlay - metallic - two surfaces	$55.00
D2543	Onlay - metallic - three surfaces	$60.00
D2544	Onlay - metallic - four or more surfaces	$65.00
D2610	Inlay - porcelain/ceramic - one surface	$215.00
D2620	Inlay - porcelain/ceramic - two surfaces	$245.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	$260.00
D2642	Onlay - porcelain/ceramic - two surfaces	$240.00
D2643	Onlay - porcelain/ceramic - three surfaces	$270.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	$285.00
D2650	Inlay - resin-based composite - one surface	$135.00
D2651	Inlay - resin-based composite - two surfaces	$155.00
D2652	Inlay - resin-based composite - three or more surfaces	$185.00
D2662	Onlay - resin-based composite - two surfaces	$180.00
D2663	Onlay - resin-based composite - three surfaces	$200.00
D2664	Onlay - resin-based composite - four or more surfaces	$235.00
D2710	Crown - resin-based composite (indirect)	$85.00
D2712	Crown - ¾ resin-based composite (indirect)	$85.00
D2720	Crown - resin with high noble metal	$245.00
D2721	Crown - resin with predominantly base metal	$145.00
D2722	Crown - resin with noble metal	$185.00
D2740	Crown - porcelain/ceramic substrate	$295.00
D2750	Crown - porcelain fused to high noble metal	$295.00

D2751	Crown - porcelain fused to predominantly base metal	$195.00
D2752	Crown - porcelain fused to noble metal	$235.00
D2780	Crown - ¾ cast high noble metal	$260.00
D2781	Crown - ¾ cast predominantly base metal	$160.00
D2782	Crown - ¾ cast noble metal	$200.00
D2783	Crown - ¾ porcelain/ceramic	$295.00
D2790	Crown - full cast high noble metal	$260.00
D2791	Crown - full cast predominantly base metal	$160.00
D2792	Crown - full cast noble metal	$200.00
D2794	Crown - titanium	$295.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10.00
D2920	Re-cement or re-bond crown	$10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	$40.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	$30.00
D2930	Prefabricated stainless steel crown - primary tooth	$25.00
D2931	Prefabricated stainless steel crown - permanent tooth	$25.00
D2932	Prefabricated resin crown - *anterior primary tooth*	$35.00
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	$30.00
D2940	Protective restoration	$10.00
D2941	Interim therapeutic restoration - primary dentition	$10.00
D2949	Restorative foundation for an indirect restoration	$20.00
D2950	Core buildup, including any pins when required	$20.00
D2951	Pin retention - per tooth, in addition to restoration	$15.00
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	$60.00
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	$45.00
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	$45.00
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	$35.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$39.00
D2980	Crown repair necessitated by restorative material failure	$20.00
D2981	Inlay repair necessitated by restorative material failure	$20.00
D2982	Onlay repair necessitated by restorative material failure	$20.00
D2983	Veneer repair necessitated by restorative material failure	$20.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$10.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$15.00
D3221	Pulpal debridement, primary and permanent teeth	$20.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$15.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$30.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$30.00
D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$85.00
D3320	*Root canal* - endodontic therapy, bicuspid tooth (excluding final restoration)	$150.00
D3330	*Root canal* - endodontic therapy, molar (excluding final restoration)	$280.00
D3331	Treatment of root canal obstruction; non-surgical access	$85.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$85.00
D3333	Internal root repair of perforation defects	$85.00
D3346	Retreatment of previous root canal therapy - anterior	$115.00
D3347	Retreatment of previous root canal therapy - bicuspid	$180.00
D3348	Retreatment of previous root canal therapy - molar	$310.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$80.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$55.00

D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) $55.00
D3410 Apicoectomy - anterior $90.00
D3421 Apicoectomy - bicuspid (first root) $100.00
D3425 Apicoectomy - molar (first root) $110.00
D3426 Apicoectomy (each additional root) $65.00
D3427 Periradicular surgery without apicoectomy $90.00
D3430 Retrograde filling - per root $60.00
D3450 Root amputation - per root ..... No Cost
D3920 Hemisection (including any root removal), not including root canal therapy $40.00

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant $135.00
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant $80.00
D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth $80.00
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant $135.00
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant $80.00
D4245 Apically positioned flap $130.00
D4249 Clinical crown lengthening - hard tissue $125.00
D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant $300.00
D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant $240.00
D4263 Bone replacement graft - first site in quadrant $215.00
D4264 Bone replacement graft - each additional site in quadrant $80.00
D4270 Pedicle soft tissue graft procedure $215.00
D4274 Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area) $50.00
D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft $215.00
D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site $215.00
D4341 Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months* $40.00
D4342 Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months* $30.00
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis - *limited to 1 treatment in any 12 consecutive months* $40.00
D4910 Periodontal maintenance - *limited to 1 treatment each 6 month period* $30.00
D4910 *Additional periodontal maintenance (within the 6 month period)* $55.00
D4921 Gingival irrigation - per quadrant ..... No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.
- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.
- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

D5110 Complete denture - maxillary $215.00
D5120 Complete denture - mandibular $215.00
D5130 Immediate denture - maxillary $235.00
D5140 Immediate denture - mandibular $235.00
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) $180.00
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) $180.00
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) $240.00

D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$240.00
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$180.00
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$180.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$240.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$240.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$290.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$290.00
D5410	Adjust complete denture - maxillary	$10.00
D5411	Adjust complete denture - mandibular	$10.00
D5421	Adjust partial denture - maxillary	$10.00
D5422	Adjust partial denture - mandibular	$10.00
D5510	Repair broken complete denture base	$25.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$15.00
D5610	Repair resin denture base	$25.00
D5620	Repair cast framework	$25.00
D5630	Repair or replace broken clasp - per tooth	$25.00
D5640	Replace broken teeth - per tooth	$15.00
D5650	Add tooth to existing partial denture	$15.00
D5660	Add clasp to existing partial denture - per tooth	$15.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$150.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$150.00
D5710	Rebase complete maxillary denture	$70.00
D5711	Rebase complete mandibular denture	$70.00
D5720	Rebase maxillary partial denture	$70.00
D5721	Rebase mandibular partial denture	$70.00
D5730	Reline complete maxillary denture (chairside)	$35.00
D5731	Reline complete mandibular denture (chairside)	$35.00
D5740	Reline maxillary partial denture (chairside)	$35.00
D5741	Reline mandibular partial denture (chairside)	$35.00
D5750	Reline complete maxillary denture (laboratory)	$75.00
D5751	Reline complete mandibular denture (laboratory)	$75.00
D5760	Reline maxillary partial denture (laboratory)	$75.00
D5761	Reline mandibular partial denture (laboratory)	$75.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$90.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$90.00
D5850	Tissue conditioning, maxillary	$15.00
D5851	Tissue conditioning, mandibular	$15.00

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])

- When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional $100.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	$260.00
D6211	Pontic - cast predominantly base metal	$160.00
D6212	Pontic - cast noble metal	$200.00
D6240	Pontic - porcelain fused to high noble metal	$295.00
D6241	Pontic - porcelain fused to predominantly base metal	$195.00
D6242	Pontic - porcelain fused to noble metal	$235.00
D6245	Pontic - porcelain/ceramic	$295.00
D6250	Pontic - resin with high noble metal	$245.00
D6251	Pontic - resin with predominantly base metal	$145.00

D6252	Pontic - resin with noble metal	$195.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$245.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$260.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$150.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$155.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$50.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$55.00
D6606	Retainer inlay - cast noble metal, two surfaces	$90.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$95.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$240.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$270.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$155.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$160.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$55.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$65.00
D6614	Retainer onlay - cast noble metal, two surfaces	$95.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$105.00
D6720	Retainer crown - resin with high noble metal	$245.00
D6721	Retainer crown - resin with predominantly base metal	$145.00
D6722	Retainer crown - resin with noble metal	$185.00
D6740	Retainer crown - porcelain/ceramic	$295.00
D6750	Retainer crown - porcelain fused to high noble metal	$295.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$195.00
D6752	Retainer crown - porcelain fused to noble metal	$235.00
D6780	Retainer crown - ¾ cast high noble metal	$260.00
D6781	Retainer crown - ¾ cast predominantly base metal	$160.00
D6782	Retainer crown - ¾ cast noble metal	$200.00
D6783	Retainer crown - ¾ porcelain/ceramic	$295.00
D6790	Retainer crown - full cast high noble metal	$260.00
D6791	Retainer crown - full cast predominantly base metal	$160.00
D6792	Retainer crown - full cast noble metal	$200.00
D6930	Re-cement or re-bond fixed partial denture	$15.00
D6940	Stress breaker	$25.00
D6980	Fixed partial denture repair necessitated by restorative material failure	$30.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - deciduous tooth	$5.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$8.00
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$45.00
D7220	Removal of impacted tooth - soft tissue	$55.00
D7230	Removal of impacted tooth - partially bony	$75.00
D7240	Removal of impacted tooth - completely bony	$95.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$115.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$25.00
D7251	Coronectomy - intentional partial tooth removal	$115.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$95.00
D7280	Surgical access of an unerupted tooth	$120.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$120.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	$25.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$70.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost

D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	$25.00
D7472	Removal of torus palatinus	$25.00
D7473	Removal of torus mandibularis	$25.00
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	$60.00
D7971	Excision of pericoronal gingiva	$60.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

	The benefit for pre-treatment records and diagnostic services includes:	$200.00
D0210	Intraoral - complete series of radiographic images	
D0322	Tomographic survey	
D0330	Panoramic radiographic image	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	
D0350	2D oral/facial photographic images obtained intraorally or extraorally	
D0351	3D photographic image	
D0470	Diagnostic casts	
	The benefit for post-treatment records includes:	$70.00
D0210	Intraoral - complete series of radiographic images	
D0470	Diagnostic casts	
D8010	Limited orthodontic treatment of the primary dentition	$950.00
D8020	Limited orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$950.00
D8030	Limited orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$950.00
D8040	Limited orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$1,150.00
D8050	Interceptive orthodontic treatment of the primary dentition	$950.00
D8060	Interceptive orthodontic treatment of the transitional dentition	$950.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$1,700.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$1,700.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$1,900.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for deep sedation or general anesthesia	No Cost
D9223	Deep sedation/general anesthesia - each 15 minute increment	$80.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment	$80.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$10.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5.00
D9440	Office visit - after regularly scheduled hours	$25.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9940	Occlusal guard, by report - *limited to 1 in 3 years*	$105.00
D9943	Occlusal guard adjustment	$10.00

D9951	Occlusal adjustment, limited	$50.00
D9952	Occlusal adjustment, complete	$70.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Delta Dental. The Enrollee pays the Copayment specified for such services.

Procedures not listed above are not covered, however, may be available at the Contract Dentist's "filed fees." "Filed fees" means the Contract Dentist's fees on file with Delta Dental. Questions regarding these fees should be directed to the Customer Service department at 800-422-4234.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Delta Dental, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A, Description of Benefits and Copayments.*
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, a preauthorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.
11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.

13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedure D9940 (occlusal guard, per report).
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

SmileWay® Wellness Program

Find all of our dental health resources, including a risk assessment tool, articles, videos and a free e-newsletter subscription, at: **mysmileway.com**.

DeltaCare USA Customer Service

800-422-4234

NOTE: THIS IS ONLY A BRIEF SUMMARY OF THE PLAN.

The Group Dental Service Contract must be consulted to determine the exact terms and conditions of coverage. An Evidence of Coverage will be sent to you upon enrollment. **If you wish to review an Evidence of Coverage prior to enrollment, you may request a copy by calling Customer Service at 800-422-4234.**

In California, DeltaCare USA is underwritten by Delta Dental of California and administered by Delta Dental Insurance Company. These companies are financially responsible for their own products.

Customer Service
800-422-4234
Monday through Friday
5 a.m. to 6 p.m., Pacific time

Provided by:
Delta Dental of California
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90703

Administered by:
Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023

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CharterLIFE™
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VSP Vision

Summary of Coverage

A Look at Your VSP Vision Coverage

With VSP and CharterLIFE, your health comes first.

As a member, you'll get access to savings and personalized vision care from a VSP network doctor for you and your family.

Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.

vsp PREMIER edge

With thousands of choices, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

Shop online and connect your benefits.

eyeconic a vsp vision company

Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using your benefit is easy!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

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CharterLIFE and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Signature
EFFECTIVE DATE:
01/01/2024

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening	$10 Up to $39	Every calendar year
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	$20 per exam	Available as needed
PRESCRIPTION GLASSES		**$25**	See frame and lenses
FRAME[+]	• $220 Featured Frame Brands allowance • $200 frame allowance • 20% savings on the amount over your allowance • $110 Walmart/Sam's Club/Costco frame allowance	Included in Prescription Glasses	Every calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Impact-resistant lenses • UV protection • Average savings of 40% on other lens enhancements	$0 $80 - $90 $120 - $160 $0 $0	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 30% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% savings from a VSP provider within 12 months of your last WellVision Exam.		
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities. • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers**/special-offers/hearing-aids for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		

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With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. Premier Edge is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

CharterLIFE™
Believe Build Benefit

UNUM

Group Life Insurance and AD&D

Better benefits at work.

CharterLIFE

Term Life with Accidental Death & Dismemberment (AD&D) Insurance

can provide money for your family if you die or are diagnosed with a terminal illness.

How does it work?

You keep coverage for a set period of time, or "term." If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more.

AD&D Insurance is also available, which can pay a benefit if you survive an accident but have certain serious injuries. It can pay an additional amount if you die from a covered accident.

Why choose Unum?

Your employer is offering you this coverage at no cost to you. Unum is the leading provider of employee benefits, with more than 165 years of experience.[1] We'll be there to back our benefits and provide you with the support you need.

Who can get Term Life coverage?

If you are actively at work at least 30 hours per week, you can receive coverage for:

You	You can receive a benefit amount of $50,000.

Who can get Accidental Death & Dismemberment (AD&D) coverage?

You	You can receive an AD&D benefit amount of $50,000.

No questions or health exams required for AD&D coverage.

What else is included?

A "Living" Benefit

If you are diagnosed with a terminal illness with less than 12 months to live, you can request 75% of your life insurance benefit (up to $500,000) while you are still living. This amount will be taken out of the death benefit and may be taxable.

Waiver of premium

Your cost may be waived if you are totally disabled for a period of time.

Portability

You may be able to keep coverage if you leave the company, retire or change the number of hours you work.

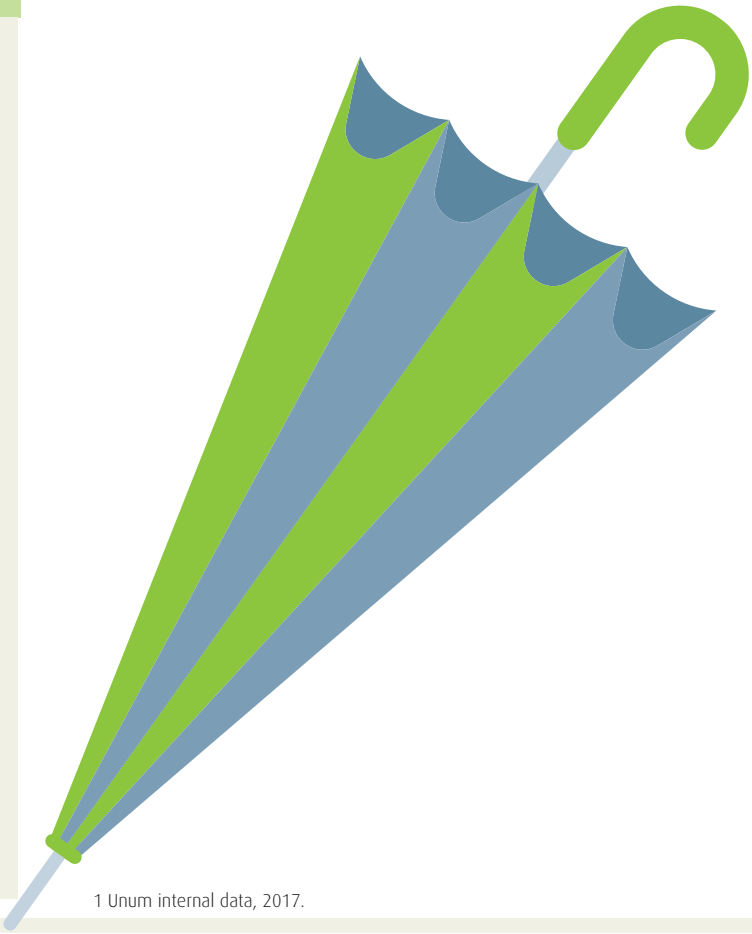
Employees or dependents who have a sickness or injury having a material effect on life expectancy at the time their group coverage ends are not eligible for portability.

Work-life balance Employee Assistance Program (EAP)

Get access to professional help for a range of personal and work-related issues, including counselor referrals, financial planning and legal support.

Worldwide emergency travel assistance

One phone call gets you and your family immediate help anywhere in the world, as long as you're traveling 100 or more miles from home. However, a spouse traveling on business for his or her employer is not covered.



1 Unum internal data, 2017.

Term Life Insurance with Accidental Death & Dismemberment (AD&D)

Exclusions and limitations

Actively at work

Eligible employees must be actively at work to apply for coverage. Being actively at work means on the day the employee applies for coverage, the individual must be working at one of his/her company's business locations; or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence or lay off.

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage.

Employees must be actively employed in the United States with the Employer to receive coverage. Employees must be insured under the plan for spouses and dependents to be eligible for coverage.

Exclusions and limitations

Life insurance benefits will not be paid for deaths caused by suicide occurring within 24 months after the effective date of coverage. The same applies for increased or additional benefits.

AD&D specific exclusions and limitations:

Accidental death and dismemberment benefits will not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body; diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)
- Suicide, self-destruction while sane, intentionally self-inflicted injury while sane or self-inflicted injury while insane
- War, declared or undeclared, or any act of war
- Active participation in a riot
- Committing or attempting to commit a crime under state or federal law
- The voluntary use of any prescription or non-prescription drug, poison, fume or other chemical substance unless used according to the prescription or direction of your doctor. This exclusion does not apply to you if the chemical substance is ethanol.
- Intoxication – "Being intoxicated" means your blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.

Delayed effective date of coverage

Employee: Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Age reduction

Coverage amounts for Life and AD&D Insurance for you will reduce to 65% of the original amount when you reach age 70, and will reduce to 50% of the original amount when you reach age 75. Coverage may not be increased after a reduction.

Termination of coverage

Your coverage under the policy ends on the earliest of:

- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are actively employed (unless coverage is continued due to a covered layoff, leave of absence, injury or sickness), as described in the certificate of coverage

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form C.FP-1 et al or contact your Unum representative.

Life Planning Financial & Legal Resources services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Work-life balance EAP

The work-life balance employee assistance program, provided by HealthAdvocate, is available with select unum insurance offerings, Terms and availability of service are subjet to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Worldwide emergency travel assistance

Worldwide emergency travel assistance services, provided by Assist America, Inc., are available with select Unum insurance offerings. Terms and availability of service are subject to chance and prior notification requirements. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Underwritten by:
Unum Life Insurance Company of America, Portland, Maine

Better benefits at work.

CharterLIFE

Term Life with Accidental Death & Dismemberment (AD&D) Insurance

can provide money for your family if you die or are diagnosed with a terminal illness.

How does it work?

You keep coverage for a set period of time, or "term." If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more.

AD&D Insurance is also available, which can pay a benefit if you survive an accident but have certain serious injuries. It can pay an additional amount if you die from a covered accident.

Why choose Unum?

Your employer is offering you this coverage at no cost to you. Unum is the leading provider of employee benefits, with more than 165 years of experience.[1] We'll be there to back our benefits and provide you with the support you need.

Who can get Term Life coverage?

If you are actively at work at least 30 hours per week, you can receive coverage for:

You	You can receive a benefit amount of $25,000.

Who can get Accidental Death & Dismemberment (AD&D) coverage?

You	You can receive an AD&D benefit amount of $25,000.

No questions or health exams required for AD&D coverage.

What else is included?

A "Living" Benefit

If you are diagnosed with a terminal illness with less than 12 months to live, you can request 75% of your life insurance benefit (up to $500,000) while you are still living. This amount will be taken out of the death benefit and may be taxable.

Waiver of premium

Your cost may be waived if you are totally disabled for a period of time.

Portability

You may be able to keep coverage if you leave the company, retire or change the number of hours you work.

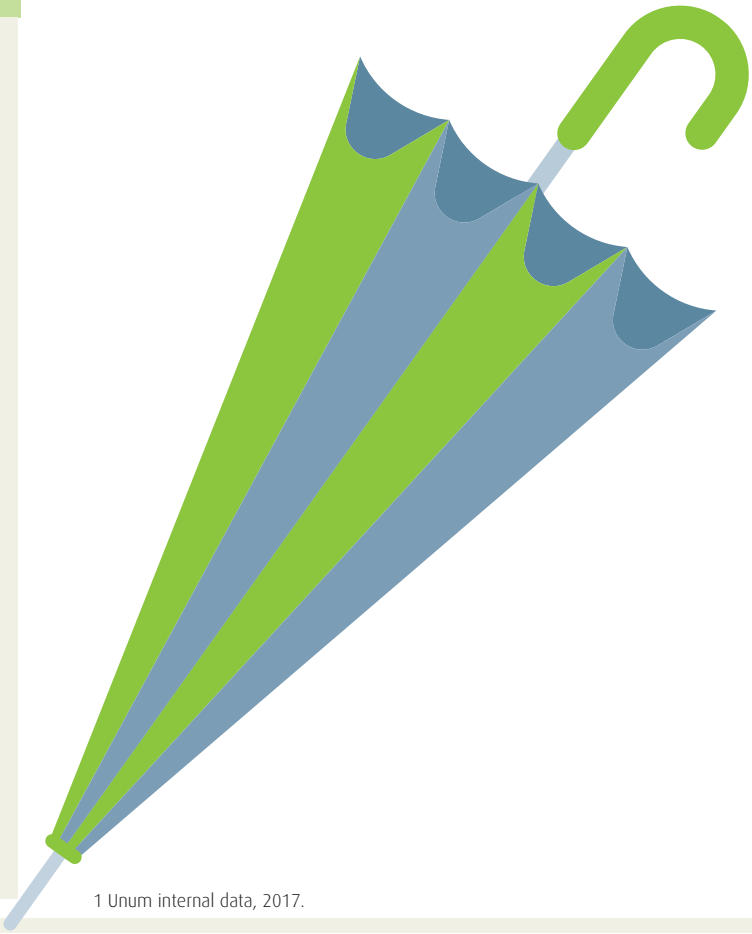
Employees or dependents who have a sickness or injury having a material effect on life expectancy at the time their group coverage ends are not eligible for portability.

Work-life balance Employee Assistance Program (EAP)

Get access to professional help for a range of personal and work-related issues, including counselor referrals, financial planning and legal support.

Worldwide emergency travel assistance

One phone call gets you and your family immediate help anywhere in the world, as long as you're traveling 100 or more miles from home. However, a spouse traveling on business for his or her employer is not covered.



1 Unum internal data, 2017.

Term Life Insurance with Accidental Death & Dismemberment (AD&D)

Exclusions and limitations

Actively at work

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Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage.

Employees must be actively employed in the United States with the Employer to receive coverage. Employees must be insured under the plan for spouses and dependents to be eligible for coverage.

Exclusions and limitations

Life insurance benefits will not be paid for deaths caused by suicide occurring within 24 months after the effective date of coverage. The same applies for increased or additional benefits.

AD&D specific exclusions and limitations:

Accidental death and dismemberment benefits will not be paid for losses caused by, contributed to by, or resulting from:

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- Suicide, self-destruction while sane, intentionally self-inflicted injury while sane or self-inflicted injury while insane
- War, declared or undeclared, or any act of war
- Active participation in a riot
- Committing or attempting to commit a crime under state or federal law
- The voluntary use of any prescription or non-prescription drug, poison, fume or other chemical substance unless used according to the prescription or direction of your doctor. This exclusion does not apply to you if the chemical substance is ethanol.
- Intoxication – "Being intoxicated" means your blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.

Delayed effective date of coverage

Employee: Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Age reduction

Coverage amounts for Life and AD&D Insurance for you will reduce to 65% of the original amount when you reach age 70, and will reduce to 50% of the original amount when you reach age 75. Coverage may not be increased after a reduction.

Termination of coverage

Your coverage under the policy ends on the earliest of:

- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are actively employed (unless coverage is continued due to a covered layoff, leave of absence, injury or sickness), as described in the certificate of coverage

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Work-life balance EAP

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Worldwide emergency travel assistance

Worldwide emergency travel assistance services, provided by Assist America, Inc., are available with select Unum insurance offerings. Terms and availability of service are subject to chance and prior notification requirements. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Underwritten by:
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Better benefits at work.

CharterLIFE

Term Life with Accidental Death & Dismemberment (AD&D) Insurance

can provide money for your family if you die or are diagnosed with a terminal illness.

How does it work?

You keep coverage for a set period of time, or "term." If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more.

AD&D Insurance is also available, which can pay a benefit if you survive an accident but have certain serious injuries. It can pay an additional amount if you die from a covered accident.

Why choose Unum?

Your employer is offering you this coverage at no cost to you. Unum is the leading provider of employee benefits, with more than 165 years of experience.[1] We'll be there to back our benefits and provide you with the support you need.

Who can get Term Life coverage?

If you are actively at work at least 30 hours per week, you can receive coverage for:

You	You can receive 2 times your earnings up to a maximum of $150,000. You can get up to $150,000 with no health questions.

Who can get Accidental Death & Dismemberment (AD&D) coverage?

You	You can get 2 times your earnings of AD&D coverage up to a maximum of $150,000.

No questions or health exams required for AD&D coverage.

What else is included?

A "Living" Benefit

If you are diagnosed with a terminal illness with less than 12 months to live, you can request 75% of your life insurance benefit (up to $500,000) while you are still living. This amount will be taken out of the death benefit and may be taxable.

Waiver of premium

Your cost may be waived if you are totally disabled for a period of time.

Portability

You may be able to keep coverage if you leave the company, retire or change the number of hours you work.

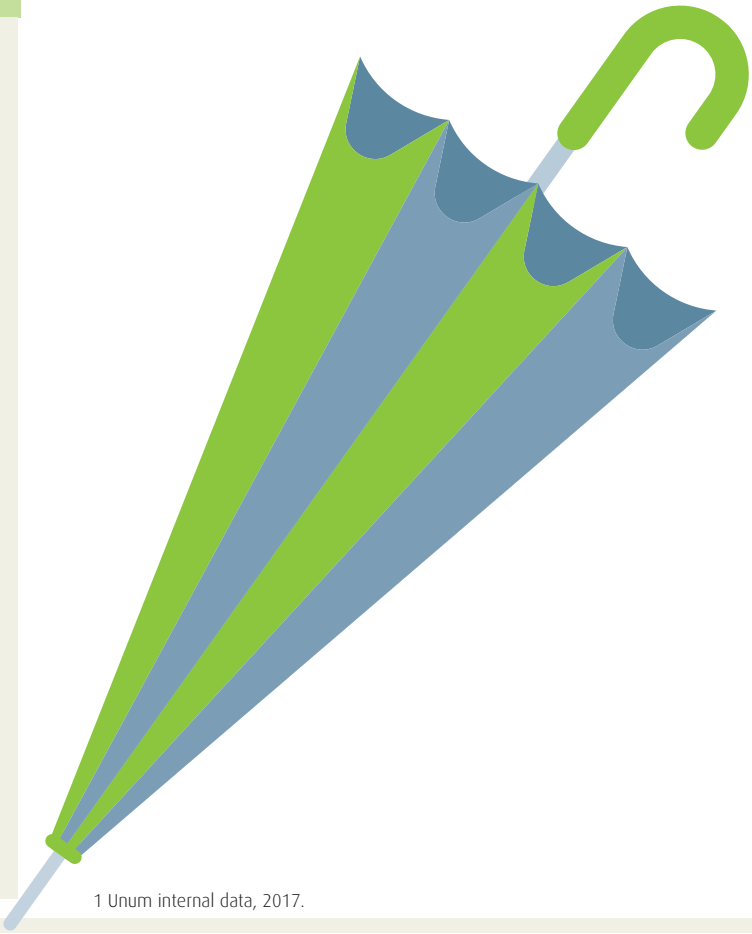
Employees or dependents who have a sickness or injury having a material effect on life expectancy at the time their group coverage ends are not eligible for portability.

Work-life balance Employee Assistance Program (EAP)

Get access to professional help for a range of personal and work-related issues, including counselor referrals, financial planning and legal support.

Worldwide emergency travel assistance

One phone call gets you and your family immediate help anywhere in the world, as long as you're traveling 100 or more miles from home. However, a spouse traveling on business for his or her employer is not covered.



1 Unum internal data, 2017.

Term Life Insurance with Accidental Death & Dismemberment (AD&D)

Exclusions and limitations

Actively at work

Eligible employees must be actively at work to apply for coverage. Being actively at work means on the day the employee applies for coverage, the individual must be working at one of his/her company's business locations; or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence or lay off.

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage.

Employees must be actively employed in the United States with the Employer to receive coverage. Employees must be insured under the plan for spouses and dependents to be eligible for coverage.

Exclusions and limitations

Life insurance benefits will not be paid for deaths caused by suicide occurring within 24 months after the effective date of coverage. The same applies for increased or additional benefits.

AD&D specific exclusions and limitations:

Accidental death and dismemberment benefits will not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body; diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)
- Suicide, self-destruction while sane, intentionally self-inflicted injury while sane or self-inflicted injury while insane
- War, declared or undeclared, or any act of war
- Active participation in a riot
- Committing or attempting to commit a crime under state or federal law
- The voluntary use of any prescription or non-prescription drug, poison, fume or other chemical substance unless used according to the prescription or direction of your doctor. This exclusion does not apply to you if the chemical substance is ethanol.
- Intoxication – "Being intoxicated" means your blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.

Delayed effective date of coverage

Employee: Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Age reduction

Coverage amounts for Life and AD&D Insurance for you will reduce to 65% of the original amount when you reach age 70, and will reduce to 50% of the original amount when you reach age 75. Coverage may not be increased after a reduction.

Termination of coverage

Your coverage under the policy ends on the earliest of:

- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are actively employed (unless coverage is continued due to a covered layoff, leave of absence, injury or sickness), as described in the certificate of coverage

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Work-life balance EAP

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Worldwide emergency travel assistance

Worldwide emergency travel assistance services, provided by Assist America, Inc., are available with select Unum insurance offerings. Terms and availability of service are subject to chance and prior notification requirements. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Underwritten by:
Unum Life Insurance Company of America, Portland, Maine

CharterLIFE™
Believe Build Benefit

Voluntary Plans

CharterLIFE™
Believe Build Benefit

UNUM

Voluntary Life Insurance and AD&D

Term Life and Accidental Death & Dismemberment (AD&D) Insurance

can provide money for your family if you die or are diagnosed with a terminal illness.

How does it work?

You choose the amount of coverage that's right for you, and you keep coverage for a set period of time, or "term." If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more.

AD&D Insurance is also available, which pays a benefit if you survive an accident but have certain serious injuries. It pays an additional amount if you die from a covered accident.

Why is this coverage so valuable?

If you previously purchased coverage, you can increase it up to $200,000 to meet your growing needs — with no health questions or exams.

What else is included?

A "Living" Benefit

If you are diagnosed with a terminal illness with less than 12 months to live, you can request 100% of your life insurance benefit (up to $250,000) while you are still living. This amount will be taken out of the death benefit. These benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlement, and may be taxable. Recipients should consult their tax attorney or advisor before utilizing living benefit payments.

Waiver of premium

Your cost may be waived if you are totally disabled for a period of time.

Portability

You may be able to keep coverage if you leave the company, retire or change the number of hours you work.

Employees or dependents who have a sickness or injury having a material effect on life expectancy at the time their group coverage ends are not eligible for portability.

Who can get Term Life coverage?

If you are actively at work at least 20 hours per week, you may apply for coverage for:

You	Choose from $10,000 to $500,000 in $10,000 increments, up to 5 times your earnings. If you previously purchased coverage, you can increase it up to $200,000, your guaranteed issue amount, with no health questions. If you previously declined coverage, you may have to answer some health questions.
Your Spouse	Get up to $100,000 of coverage in $50,000 increments. Spouse coverage cannot exceed 100% of the coverage amount you purchase for yourself. If you previously purchased coverage for your spouse, they can increase their coverage up to $50,000, their guaranteed issue amount, with no health questions or exams, if eligible (see delayed effective date). If you previously declined spouse coverage, some health questions may be required.
Your Children	Get up to $10,000 of coverage in $2,000 increments if eligible (see delayed effective date). One policy covers all of your children until their 26th birthday. The maximum benefit for children live birth to 6 months is $1,000.

Who can get Accidental Death & Dismemberment (AD&D) coverage?

You:	Get up to $500,000 of AD&D coverage for yourself in $10,000 increments to a maximum of 5 times your earnings.
Your Spouse:	Get up to $100,000 of AD&D coverage for your spouse in $5,000 increments, if eligible (see delayed effective date).
Your Children:	Get up to $10,000 of coverage for your children in $2,000 increments if eligible (see delayed effective date).

No questions or health exams required for AD&D coverage. Delayed Effective Date: If your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Payment of premium does not guarantee coverage. Please refer to your policy contract or see your plan administrator for an explanation of the delayed effective date provision that applies to your plan.

Term Life and Accidental Death & Dismemberment (AD&D) Insurance

How much coverage can I get?

Calculate your costs

1. **Enter the coverage amount you want.**
2. **Divide by the amount shown.**
3. **Multiply by the rate. Use the rate table (at right) to find the rate based on age.**
   (Choose the age you will be when your coverage becomes effective. To determine your spouse rate, choose the age the spouse will be when coverage becomes effective. See your plan administrator for your plan effective date.)
4. **Enter your cost.**

	1	2	3	4
Employee	$_____,000	÷ $1,000 = $_____	X $_____	= $_____
Spouse	$_____,000	÷ $1,000 = $_____	X $_____	= $_____
Child	$_____,000	÷ $1,000 = $_____	X $_____	= $_____
			Total cost	

Employee monthly rate	
Age	Per $1,000 of coverage
	Cost
15-24	$0.070
25-29	$0.070
30-34	$0.080
35-39	$0.100
40-44	$0.150
45-49	$0.260
50-54	$0.430
55-59	$0.680
60-64	$1.060
65-69	$1.900
70-74	$3.390
75+	$5.600

Spouse monthly rate	
Per $1,000 of coverage	
Cost	
$0.070	
$0.070	
$0.080	
$0.100	
$0.150	
$0.260	
$0.043	
$0.680	
$1.060	
$1.900	
$3.390	
$5.600	

Child monthly rate
$0.160 per $1,000 of coverage

1. **Enter the AD&D coverage amount you want.**
2. **Divide by the amount shown.**
3. **Multiply by the rate. Use the AD&D rate table (at right) to find the rate.**
4. **Enter your cost.**

AD&D	1	2	3	4
Employee	$_____,000	÷ $1,000 = $_____	X $0.020	= $_____
Spouse	$_____,000	÷ $1,000 = $_____	X $0.020	= $_____
Child	$_____,000	÷ $1,000 = $_____	X $0.020	= $_____
			Total cost	

AD&D monthly rates		
	Coverage amount	Rate
Employee	per $1,000 of coverage	$0.020
Spouse	per $1,000 of coverage	$0.020
Child	per $1,000 of coverage	$0.020

Billed amount may vary slightly.
If you apply for coverage above the guaranteed issue amount, you will be asked health-related questions which may affect your ability to get the larger coverage amount. In order to purchase coverage for your dependents, you must buy coverage for yourself. Coverage amounts cannot exceed 100% of your coverage amounts.

Term Life and Accidental Death & Dismemberment (AD&D) Insurance

Exclusions and limitations

Actively at work

Eligible employees must be actively at work to apply for coverage. Being actively at work means on the day the employee applies for coverage, the individual must be working at one of his/her company's business locations; or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence or lay off.

An unmarried handicapped dependent child who becomes handicapped prior to the child's attainment age of 26 may be eligible for benefits. Please see your plan administrator for details on eligibility.

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage. Spouses and dependents must live in the U.S. to receive coverage.

Employees must be actively employed in the United States with the Employer to receive coverage. Employees must be insured under the plan for spouses and dependents to be eligible for coverage.

Exclusions and limitations

Life insurance benefits will not be paid for deaths caused by suicide occurring within 24 months after the effective date of coverage. The same applies for increased or additional benefits.

AD&D specific exclusions and limitations:

Accidental death and dismemberment benefits will not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body; diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)
- Suicide, self-destruction while sane, intentionally self-inflicted injury while sane or self-inflicted injury while insane
- War, declared or undeclared, or any act of war
- Active participation in a riot
- Committing or attempting to commit a crime under state or federal law
- The voluntary use of any prescription or non-prescription drug, poison, fume or other chemical substance unless used according to the prescription or direction of your or your dependent's doctor. This exclusion does not apply to you or your dependent if the chemical substance is ethanol.
- Intoxication – "Being intoxicated" means your or your dependent's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.

Delayed effective date of coverage

Insurance coverage will be delayed if you are not an active employee because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Delayed Effective Date: If your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Payment of premium does not guarantee coverage. Please refer to your policy contract or see your plan administrator for an explanation of the delayed effective date provision that applies to your plan.

Age reduction

Coverage amounts for Life and AD&D Insurance for you and your dependents will reduce to:

65% of the original amount when you reach age 70

50% of the original amount when you reach age 75

25% of the original amount when you reach age 85

Termination of coverage

Your coverage and your dependents' coverage under the policy ends on the earliest of:

- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are actively employed (unless coverage is continued due to a covered layoff, leave of absence, injury or sickness), as described in the certificate of coverage

In addition, coverage for any one dependent will end on the earliest of:

- The date your coverage under a plan ends
- The date your dependent ceases to be an eligible dependent
- For a spouse, the date of a divorce or annulment
- For dependents, the date of your death

Unum will provide coverage for a payable claim that occurs while you and your dependents are covered under the policy or plan.

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Unum complies with state civil union and domestic partner laws when applicable.

Underwritten by:

Unum Life Insurance Company of America, Portland, Maine

Colonial Life

Group Accident

Group Accident Insurance

Colonial Life®

You can't predict when or where an accident will strike. But you can make sure you have a safety net of financial protection to help if an accidental injury occurs.

Accidents can happen anytime, anywhere—at home or at work, on the playground or on the road. Some of the most common injuries include:

- Broken bones
- Burns
- Concussions
- Lacerations
- Back or knee injuries
- Accidental injuries that send you to the Emergency Room, Urgent Care or a doctor's office.

Colonial Life's Group Accident Insurance helps you fill some of the gaps caused by increasing deductibles, co-payments and out-of-pocket costs related to an accidental injury. With this coverage you may not need to use your savings or secure a loan to help pay those unexpected out-of-pocket expenses associated with a covered accident.

Here's how it works...

Imagine while cleaning the gutters, you fall from the ladder and break your leg.

These are out-of-pocket expenses you may encounter:

$100	Emergency room co-pay
$250	Deductible (co-pays do not count toward deductible)
$35	Specialist visit co-pay – orthopedic physician
$350	Specialist visit co-pay – occupational/physical therapy for 10 days
$735	**Out-of-pocket expenses**

And here is a sample of benefits you may be eligible for with Colonial Life's Group Accident Insurance:

$75	Accident Emergency Treatment
$100	Accident Follow-up Doctor Visit ($50 per visit, up to 2 per accident)
$50	Appliance (crutches)
$675	Fracture (broken leg)
$150	Occupational/Physical Therapy ($15/day for 10 days)
$20	X-Ray (for diagnosis of broken leg)

$1,070 of benefits paid to you in addition to other coverage you may have with other insurance companies.

The claims example above is based on a covered person age 41 who receives a complete fracture of the leg and requires non-surgical repair. The policy has exclusions and limitations. Costs of treatment and benefit amounts may vary.

Benefits listed are for each covered person per covered accident unless otherwise specified.

Initial Care

- Accident Emergency Treatment $75
- Air Ambulance $1,000
- Ambulance $100
- X-Ray $20

Common Accidental Injuries

Dislocation (Separated Joint)	Non-Surgical	Surgical
Hip	$1,800	$3,600
Knee	$900	$1,800
Ankle – Bone or Bones of the Foot	$720	$1,440
Collarbone (sternoclavicular)	$450	$900
Lower Jaw, Shoulder, Elbow, Wrist	$270	$540
Bone or Bones of the Hand	$270	$540
Collarbone (acromioclavicular and separation)	$90	$180
One Toe or Finger	$90	$180

Fracture (Broken Bone)	Non-Surgical	Surgical
Depressed Skull	$2,250	$4,500
Non-Depressed Skull	$900	$1,800
Hip, Thigh	$1,350	$2,700
Body of Vertebrae, Pelvis, Leg	$675	$1,350
Bones of Face or Nose	$315	$630
Upper Jaw, Maxilla	$315	$630
Upper Arm between Elbow and Shoulder	$315	$630
Lower Jaw, Mandible; Kneecap, Ankle, Foot	$270	$540
Shoulder Blade, Collarbone, Vertebral Process	$270	$540
Forearm, Wrist, Hand	$270	$540
Rib	$225	$450
Coccyx	$180	$360
Finger, Toe	$90	$180

Your Colonial Life certificate also provides benefits for the following injuries received as a result of a covered accident.

- Burn (based on size and degree) ..... $750 to $9,000
- Burn – Skin Graft for 2nd or 3rd degree burns ..... 50% of Burn benefit
- Coma $5,000
- Concussion $100
- Emergency Dental Work ..... $50 Extraction, $150 Crown, Implant, or Denture
- Lacerations (based on size) ..... $25 to $600

Requires Surgery

- Eye Injury $200
- Ruptured Disc $500
- Tendon/Ligament/Rotator Cuff ..... $500 – one, $750 – two or more
- Torn Knee Cartilage $500

Surgical Care

- Blood/Plasma/Platelets $300
- Surgery (arthroscopic or exploratory) $100
- Surgery (cranial, open abdominal or thoracic) $1,000
- Surgery (hernia) $100

Benefits listed are for each covered person per covered accident unless otherwise specified.

Transportation/Lodging Assistance

If injured, the covered person must travel more than 50 miles from residence to receive special treatment and confinement in a hospital.

- Lodging (family member or companion) ..... $100 per night up to 30 days for a hotel/motel lodging costs
- Transportation ..... $400 per round trip up to 3 round trips

Accident Hospital Care

- Hospital Admission[1] ..... $500 per accident
- Hospital ICU Admission[1] ..... $750 per accident

[1] We will not pay the hospital admission benefit and the hospital intensive care unit (ICU) admission benefit for the same covered accident simultaneously.

- Hospital Confinement[2] ..... $100 per day up to 365 days per accident
- Hospital ICU Confinement[2] ..... $200 per day up to 15 days per accident

[2] We will not pay the hospital confinement benefit and the hospital ICU confinement benefit simultaneously.

Accident Follow-Up Care

- Accident Follow-Up Doctor Visit ..... $50 (up to 2 visits per accident)
- Appliances ..... $50 (such as wheelchair, crutches)
- Medical Imaging Study ..... $100 per accident (limit 1 per covered accident and 1 per calendar year)
- Occupational or Physical Therapy ..... $15 per day up to 10 days
- Pain Management (Epidural Anesthesia) ..... $50 (limit 1 per covered accident)
- Prosthetic Devices/Artificial Limb ..... $500 – one, $1,000 – two or more
- Rehabilitation Unit Confinement [3] ..... $50 per day up to 15 days per covered accident, and 30 days per calendar year

[3] We will not pay the hospital confinement benefit and the rehabilitation unit confinement benefit simultaneously.

Accidental Dismemberment

- Loss of Finger/Toe ..... $450 – one, $900 – two or more
- Loss or Loss of Use of Hand/Foot/Sight of Eye ..... $4,500 – one, $9,000 – two or more

Catastrophic Accident

For severe injuries that result in the total and irrecoverable:

- Loss of one hand and one foot
- Loss of both hands or both feet
- Loss or loss of use of one arm and one leg
- Loss or loss of use of both arms or both legs
- Loss of the sight of both eyes
- Loss of the hearing of both ears
- Loss of the ability to speak

Named Insured ..... $25,000 Spouse ..... $25,000 Child(ren) $12,500

Six month elimination period. Payable once per lifetime for each covered person.

Accidental Death

	Accidental Death	Common Carrier
• Named Insured	$20,000	$80,000
• Spouse	$20,000	$80,000
• Child(ren)	$4,000	$16,000

Will I have to answer health questions to receive coverage?

Coverage is Guaranteed Issue. No health questions will be asked.

What additional features are included?

- Worldwide coverage
- Portable
- Compliant with Health Savings Account (HSA) guidelines

How do I know how much a benefit pays?

Benefit amounts are preset and not based on the medical expenses you are charged. You get a lump sum payment that is specific to the injury or treatment required.

Will my accident claim payment be reduced if I have other insurance?

You're paid regardless of any insurance you may have with other insurance companies, and the benefits are paid directly to you (unless you specify otherwise).

How do I file a claim?

Visit coloniallife.com or call our Customer Service Department at 1-800-325-4368 for additional information.

My Coverage Worksheet **(For use with your Colonial Life benefits counselor)**

Who will be covered? (check one)

○ Employee Only ○ Employee & Spouse

○ One-Parent Family ○ Two-Parent Family

When are covered accident benefits available? (check one)

○ On and Off-Job Benefits ○ Off-Job Only Benefits

EXCLUSIONS AND LIMITATIONS

We will not pay any benefits for losses that are caused by, contributed to by or occur as a result of: felonies or illegal occupations; hazardous avocations; racing; semi-professional or professional sports; sickness; suicide or injuries which any covered person intentionally does to himself; war or armed conflict. In addition to the exclusions listed above, we also will not pay the Catastrophic Accident benefit for injuries that are caused by or are the consequence of: birth or intoxicants and narcotics. The covered person must incur a charge and the certificate must be in force for benefits to be payable.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to policy number GACC1.0-P-CA and certificate number GACC1.0-C-CA. This is not an insurance contract and only the actual policy provisions will control.

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Group Accident Insurance

Colonial Life

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- Concussions
- Lacerations
- Back or knee injuries
- Accidental injuries that send you to the Emergency Room, Urgent Care or a doctor's office.

Colonial Life's Group Accident Insurance helps you fill some of the gaps caused by increasing deductibles, co-payments and out-of-pocket costs related to an accidental injury. With this coverage you may not need to use your savings or secure a loan to help pay those unexpected out-of-pocket expenses associated with a covered accident.

Here's how it works...

Imagine while cleaning the gutters, you fall from the ladder and break your leg.

These are out-of-pocket expenses you may encounter:

$100	Emergency room co-pay
$250	Deductible (co-pays do not count toward deductible)
$35	Specialist visit co-pay – orthopedic physician
$350	Specialist visit co-pay – occupational/physical therapy for 10 days
$735	**Out-of-pocket expenses**

And here is a sample of benefits you may be eligible for with Colonial Life's Group Accident Insurance:

$125	Accident Emergency Treatment
$150	Accident Follow-up Doctor Visit ($50 per visit, up to 3 per accident)
$100	Appliance (crutches)
$1,125	Fracture (broken leg)
$250	Occupational/Physical Therapy ($25/day for 10 days)
$30	X-Ray (for diagnosis of broken leg)

$1,780 of benefits paid to you in addition to other coverage you may have with other insurance companies.

The claims example above is based on a covered person age 41 who receives a complete fracture of the leg and requires non-surgical repair. The policy has exclusions and limitations. Costs of treatment and benefit amounts may vary.

Benefits listed are for each covered person per covered accident unless otherwise specified.

Initial Care

- Accident Emergency Treatment $125
- Ambulance $200
- Air Ambulance $1,500
- X-Ray $30

Common Accidental Injuries

Dislocation (Separated Joint)	Non-Surgical	Surgical
Hip	$3,000	$6,000
Knee	$1,500	$3,000
Ankle – Bone or Bones of the Foot	$1,200	$2,400
Collarbone (sternoclavicular)	$750	$1,500
Lower Jaw, Shoulder, Elbow, Wrist	$450	$900
Bone or Bones of the Hand	$450	$900
Collarbone (acromioclavicular and separation)	$150	$300
One Toe or Finger	$150	$300

Fracture (Broken Bone)	Non-Surgical	Surgical
Depressed Skull	$3,750	$7,500
Non-Depressed Skull	$1,500	$3,000
Hip, Thigh	$2,250	$4,500
Body of Vertebrae, Pelvis, Leg	$1,125	$2,250
Bones of Face or Nose	$525	$1,050
Upper Jaw, Maxilla	$525	$1,050
Upper Arm between Elbow and Shoulder	$525	$1,050
Lower Jaw, Mandible; Kneecap, Ankle, Foot	$450	$900
Shoulder Blade, Collarbone, Vertebral Process	$450	$900
Forearm, Wrist, Hand	$450	$900
Rib	$375	$750
Coccyx	$300	$600
Finger, Toe	$150	$300

Your Colonial Life certificate also provides benefits for the following injuries received as a result of a covered accident.

- Burn (based on size and degree) ..... $1,000 to $12,000
- Burn – Skin Graft for 2nd or 3rd degree burns ..... 50% of Burn benefit
- Coma $10,000
- Concussion $150
- Emergency Dental Work ..... $100 Extraction, $300 Crown, Implant, or Denture
- Lacerations (based on size) ..... $25 to $600

Requires Surgery

- Eye Injury $300
- Ruptured Disc $500
- Tendon/Ligament/Rotator Cuff ..... $500 – one, $750 – two or more
- Torn Knee Cartilage $500

Surgical Care

- Blood/Plasma/Platelets $300
- Surgery (arthroscopic or exploratory) $150
- Surgery (cranial, open abdominal or thoracic) $1,500
- Surgery (hernia) $200

Benefits listed are for each covered person per covered accident unless otherwise specified.

Transportation/Lodging Assistance

If injured, the covered person must travel more than 50 miles from residence to receive special treatment and confinement in a hospital.

- Lodging (family member or companion) ..... $150 per night up to 30 days for a hotel/motel lodging costs
- Transportation ..... $500 per round trip up to 3 round trips

Accident Hospital Care

- Hospital Admission[1] ..... $1,000 per accident
- Hospital ICU Admission[1] ..... $1,500 per accident

[1] We will not pay the hospital admission benefit and the hospital intensive care unit (ICU) admission benefit for the same covered accident simultaneously.

- Hospital Confinement[2] ..... $200 per day up to 365 days per accident
- Hospital ICU Confinement[2] ..... $400 per day up to 15 days per accident

[2] We will not pay the hospital confinement benefit and the hospital ICU confinement benefit simultaneously.

Accident Follow-Up Care

- Accident Follow-Up Doctor Visit ..... $50 (up to 3 visits per accident)
- Appliances ..... $100 (such as wheelchair, crutches)
- Medical Imaging Study ..... $150 per accident (limit 1 per covered accident and 1 per calendar year)
- Occupational or Physical Therapy ..... $25 per day up to 10 days
- Pain Management (Epidural Anesthesia) ..... $100 (limit 1 per covered accident)
- Prosthetic Devices/Artificial Limb ..... $500 – one, $1,000 – two or more
- Rehabilitation Unit Confinement [3] ..... $100 per day up to 15 days per covered accident, and 30 days per calendar year

[3] We will not pay the hospital confinement benefit and the rehabilitation unit confinement benefit simultaneously.

Accidental Dismemberment

- Loss of Finger/Toe ..... $750 – one, $1,500 – two or more
- Loss or Loss of Use of Hand/Foot/Sight of Eye ..... $7,500 – one, $15,000 – two or more

Catastrophic Accident

For severe injuries that result in the total and irrecoverable:

- Loss of one hand and one foot
- Loss of both hands or both feet
- Loss or loss of use of one arm and one leg
- Loss or loss of use of both arms or both legs
- Loss of the sight of both eyes
- Loss of the hearing of both ears
- Loss of the ability to speak

Named Insured ..... $50,000 Spouse ..... $50,000 Child(ren) $25,000

Six month elimination period. Payable once per lifetime for each covered person.

Accidental Death

	Accidental Death	Common Carrier
• Named Insured	$25,000	$100,000
• Spouse	$25,000	$100,000
• Child(ren)	$5,000	$20,000

Will I have to answer health questions to receive coverage?

Coverage is Guaranteed Issue. No health questions will be asked.

What additional features are included?

- Worldwide coverage
- Portable
- Compliant with Health Savings Account (HSA) guidelines

How do I know how much a benefit pays?

Benefit amounts are preset and not based on the medical expenses you are charged. You get a lump sum payment that is specific to the injury or treatment required.

Will my accident claim payment be reduced if I have other insurance?

You're paid regardless of any insurance you may have with other insurance companies, and the benefits are paid directly to you (unless you specify otherwise).

How do I file a claim?

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My Coverage Worksheet **(For use with your Colonial Life benefits counselor)**

Who will be covered? (check one)

○ Employee Only ○ Employee & Spouse

○ One-Parent Family ○ Two-Parent Family

When are covered accident benefits available? (check one)

○ On and Off-Job Benefits ○ Off-Job Only Benefits

EXCLUSIONS AND LIMITATIONS

We will not pay any benefits for losses that are caused by, contributed to by or occur as a result of: felonies or illegal occupations; hazardous avocations; racing; semi-professional or professional sports; sickness; suicide or injuries which any covered person intentionally does to himself; war or armed conflict. In addition to the exclusions listed above, we also will not pay the Catastrophic Accident benefit for injuries that are caused by or are the consequence of: birth or intoxicants and narcotics. The covered person must incur a charge and the certificate must be in force for benefits to be payable.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to policy number GACC1.0-P-CA and certificate number GACC1.0-C-CA. This is not an insurance contract and only the actual policy provisions will control.

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Colonial Life

Group Cancer

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

1200 Colonial Life Boulevard, P. O. Box 1365
Columbia, South Carolina 29202
(800) 325-4368

GROUP SPECIFIED DISEASE INSURANCE

Outline of Coverage

(Applicable to certificate form GCAN-C-CA)

THIS IS LIMITED BENEFIT GROUP SPECIFIED DISEASE COVERAGE. THE POLICY PROVIDES LIMITED BENEFITS FOR CANCER AND CANCER SCREENING PROCEDURES. BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.
If you are eligible for Medicare, review the Guide To Health Insurance for People with Medicare available from the company.

Read your certificate carefully. This outline provides a very brief description of the important features of the Group Specified Disease Insurance certificate. This is not an insurance contract and only the actual policy provisions will control. The policy sets forth in detail the rights and obligations of the policyholder, you and us. The certificate is a summary of the policy and is a written statement, including the certificate schedule, prepared by us to set forth a summary of benefits to which the covered person is entitled, to whom the benefits are payable, and limitations or requirements that may apply and amendments, riders and supplements, if any. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY.

The certificate provides benefits if the first date of diagnosis of cancer or the performance of a cancer screening test occurs: while the certificate is in force; and if the cancer or treatment is not excluded by name or specific description in the policy or certificate. Cancer must be pathologically or clinically diagnosed. If cancer is not diagnosed until after the covered person dies, we will only pay benefits for the treatment of cancer performed during the 45 day period before the covered person's death.

Benefits

$50 Cancer Screening/Wellness Benefit

We will pay this benefit if any covered person has one of the following cancer screening tests performed while his coverage is in force. This benefit is payable once per calendar year for each covered person.

Cancer screening test is defined as:

• Biopsy of skin lesion; • Bone marrow aspiration/biopsy; • Breast ultrasound; • CA 15-3 (blood test for breast cancer); • CA125 (blood test for ovarian cancer); • CEA (blood test for colon cancer); • Chest X-ray; • Colonoscopy;	• Flexible sigmoidoscopy; • Hemoccult stool analysis; • PSA (blood test for prostate cancer); • Serum Protein Electrophoresis (blood test for myeloma); • Thermography; • Virtual Colonoscopy.

Mammogram Benefit $150 per test

We will pay this benefit if a covered person receives a mammogram. The test must be performed:

- while the coverage is in force.

We will pay for one baseline mammogram if the covered person is between the ages of 35 and 39, one mammogram every two calendar years if the covered person is 40 to 49 years of age, or more frequently if recommended by the covered person's physician, and one mammogram each calendar year if the covered person is 50 years of age or older.

Pap Smear Benefit $70 per test

We will pay this benefit if a covered person receives a pap smear or ThinPrep Pap Test. The test must be performed:

- while the coverage is in force.

Hospital Confinement/Hospital Intensive Care Unit Confinement

$100 per day for first 30 days of hospital confinement in a calendar year
$200 per day for hospital confinement after the first 30 days of hospital confinement in a calendar year
$200 per day for hospital intensive care unit confinement
Maximum benefit of 180 days per calendar year for hospital confinement and hospital intensive care unit confinement combined.

We will pay the applicable benefit shown above for each day any covered person incurs charges for hospital confinement or hospital intensive care unit confinement for the treatment of cancer up to the 180-day maximum per calendar year.

Hospital Confinement/Hospital Intensive Care Unit Confinement in a U.S. Government Hospital

$100 per day for first 30 days of hospital confinement in a calendar year
$200 per day for hospital confinement after the first 30 days of hospital confinement in a calendar year
$200 per day for hospital intensive care unit confinement
Maximum benefit of 180 days per calendar year for hospital confinement and hospital intensive care unit confinement combined.

We will pay the applicable benefit shown above for each day any covered person is confined in a U. S. Government hospital or a U. S. Government hospital intensive care unit for the treatment of cancer up to the 180-day maximum per calendar year.

Ambulance **$100 per trip**

We will pay this benefit for each trip any covered person makes if a professional ambulance service transports him to or from a hospital where he is confined as an inpatient for the treatment of cancer. He must incur charges for a professional ambulance service to receive this benefit. We will pay for no more than two one-way trips each time he is confined as an inpatient for the treatment of cancer. We will pay this benefit directly to the provider unless the ambulance bill shows that all charges have been paid in full.

Private Full-Time Nursing **$100 per day**

We will pay this benefit for each day any covered person incurs charges for and uses private full-time nursing services required and authorized by his doctor while he is confined to a hospital for the treatment of cancer. Private full-time nursing must be performed by a registered, a licensed practical or a licensed vocational nurse.

Attending Physician **$50 per day up to a maximum of 180 days per calendar year**

We will pay this benefit if any covered person incurs charges for and uses the services of an attending physician while confined to a hospital for the treatment of cancer. An *attending physician* is a doctor, other than the covered person's surgeon, who performs services for him while confined to a hospital.

Radiation/Chemotherapy **$150 a day up to a maximum of $5,000 per calendar year**

We will pay this benefit for each day any covered person incurs charges for and receives one or more of the following treatments for the purpose of the destruction of malignant cells during the treatment of internal (not skin) cancer up to the calendar year maximum: teleradiotherapy, using either natural or artificially propagated radiation; interstitial or intracavitary application of radium or radioisotopes in sealed or non-sealed sources; or chemical substances that have a cancercidal effect (chemotherapy). Radiation and chemotherapy treatments must be approved for the treatment of cancer by the United States Food and Drug Administration. We will not pay for office visits, laboratory tests, diagnostic X-rays, treatment planning, simulation, treatment devices, dosimetry, radiation physics, teletherapy or other procedures related to these treatments. **This benefit is not payable for skin cancer.**

Antinausea Medication **$50 a day up to a maximum of $200 per calendar year**

We will pay this benefit for each day any covered person incurs charges for and receives antinausea medication administered in a doctor's office, clinic or hospital or has a prescription filled for antinausea medication as a result of radiation or chemotherapy treatments, up to the calendar year maximum. We will pay only one Antinausea Medication benefit per day regardless of the number of antinausea medications the covered person receives on the same day.

Blood, Plasma, Platelets and Immunoglobulins **$150 per day, up to a maximum of $5,000 per calendar year**

We will pay this benefit for each day any covered person incurs charges for and receives a transfusion of blood/plasma/platelets/immunoglobulins during the treatment of cancer, up to the calendar year maximum.

Experimental Treatment **$300 per day up to $10,000 lifetime maximum**

We will pay this benefit for each day that any covered person incurs charges for and receives hospital, medical or surgical care in connection with experimental treatment of internal (not skin) cancer. These treatments must be prescribed by a physician and must be received in an experimental cancer treatment program. Treatment must be received in the United States. **This benefit is not payable for skin cancer.** Payment of this benefit is in place of payment of any other benefit for the same covered treatments.

Hair/External Breast/Voice Box Prosthesis **$200 per calendar year**

We will pay this benefit if any covered person incurs charges for and receives a hair prosthesis, external breast prosthesis or voice box prosthesis needed as a direct result of cancer.

Supportive or Protective Care Drugs and Colony Stimulating Factors **$100 per day up to $800 calendar year maximum**

We will pay this benefit for each day that any covered person incurs charges for and receives supportive or protective care drugs and/or colony stimulating factors for the treatment of cancer, up to the calendar year maximum.

Bone Marrow Stem Cell Transplant **$10,000 per lifetime**

We will pay this benefit if any covered person incurs charges for and receives a bone marrow stem cell transplant for the treatment of cancer. We will pay this benefit only once per lifetime for each covered person.

Peripheral Stem Cell Transplant **$5,000 per lifetime**

We will pay this benefit if any covered person incurs charges for and receives a peripheral stem cell transplant for the treatment of cancer. We will pay this benefit only once per lifetime for each covered person.

Transportation **$0.40 per mile up to 700 miles per round trip**

We will pay this benefit if: any covered person travels on his doctor's advice to another city for diagnosis or treatment of his cancer; the destination is more than 50 miles one way from the city where he lives; and he is receiving treatment for internal (not skin) cancer. We will pay this benefit when charges are incurred for travel to and from his destination for either: commercial travel (plane, train or bus); or non-commercial travel (use of a personal car). **This benefit is not payable for skin cancer.**

Transportation for Companion **$0.40 per mile up to 700 miles per round trip**

We will pay this benefit for one companion to accompany any covered person to another city where he is receiving treatment for cancer if: his doctor advises treatment or diagnosis of his cancer in another city; the destination is more than 50 miles one way from the city where he lives; and he is receiving treatment for internal (not skin) cancer.

We will pay this benefit when charges are incurred for travel to and from any covered person's destination for either: commercial travel (plane, train or bus); or non-commercial travel (use of personal car). **This benefit is not payable for skin cancer.**

Lodging **$50 per day up to 70 days maximum per calendar year**

We will pay this benefit for each day any covered person or any adult companion incurs charges for lodging required while the covered person is being treated for cancer more than 50 miles from his residence. We will pay for up to 70 days per calendar year.

Surgery **$30 per surgical unit up to $1,500 per procedure**

We will pay this benefit if any covered person incurs charges for and has a surgical procedure performed by a doctor for treatment of cancer up to the maximum benefit amount.

Anesthesia **25% of the amount of the Surgery benefit paid**

We will pay this benefit if any covered person incurs charges for and receives general anesthesia administered by an anesthesiologist or a Certified Registered Nurse Anesthetist during a surgical procedure that is performed for the treatment of cancer.

$25 per procedure – We will pay this benefit if any covered person incurs charges for and receives local anesthesia during a surgical procedure performed for the treatment of cancer and for which a benefit is payable under this certificate.

Second Medical Opinion **$300 per malignant condition**

We will pay this benefit if any covered person incurs charges for and obtains a second medical opinion from another doctor on recommended surgery or treatment following the positive diagnosis of internal (not skin) cancer. We will pay this benefit only once for each cancerous condition. **This benefit is not payable for skin cancer treatment or reconstructive surgery.**

Reconstructive Surgery **$30 per surgical unit up to a maximum of $1,500 per procedure, including general anesthesia**

We will pay this benefit if a covered person incurs charges for a reconstructive surgery that: requires an incision; is performed by a doctor for treatment of cancer; and is due to internal (not skin) cancer. We will pay for no more than two surgeries per site. **This benefit is not payable for skin cancer.**

If the Reconstructive Surgery benefit is less than the maximum benefit amount allowed for this benefit, then we will also pay up to 25% of the Reconstructive Surgery benefit amount if a covered person incurs charges for and has general anesthesia administered during surgery. For the purposes of this provision, reconstructive surgery includes, but is not limited to, surgical procedures performed following a mastectomy on one breast or both breasts to reestablish symmetry between the two breasts, augmentation mammoplasty, reduction mammoplasty and mastopexy.

Prosthesis/Artificial Limb **$2,000 per device or artificial limb up to a $4,000 lifetime maximum**

We will pay this benefit if any covered person incurs charges for a surgically implanted prosthetic device or artificial limb needed as a direct result of cancer surgery, up to the lifetime maximum. We will pay for no more than one of the same type of device per site.

Outpatient Surgical Center **$250 a day up to a maximum of $750 per calendar year**

We will pay this benefit for each day any covered person incurs charges for and has surgery at an outpatient surgical center for internal (not skin) cancer, up to the calendar year maximum. **This benefit is not payable for skin cancer.**

Skilled Nursing Care Facility **$300 per day**

We will pay this benefit for each day any covered person incurs charges for and is confined to a skilled nursing care facility during the treatment of cancer. Confinement must begin within 14 days after the covered person is released from a hospital. We will pay this benefit for no more than the number of days for which we paid the Hospital Confinement/Hospital Intensive Care Unit Confinement benefit or the Hospital Confinement/ Hospital Intensive Care Unit Confinement in a U. S. Government Hospital benefit for his most recent confinement.

Hospice **$300 per day**

We will pay this benefit for each day any covered person incurs charges for and: receives a visit from a representative of a hospice at home; uses the services of a hospital or a U.S. Government Hospital on an outpatient basis under the direction of a hospice; visits a hospice on an outpatient basis for treatment or services as the result of cancer; or is confined to a hospice facility.

Home Health Care Services **$300 per day**

We will pay this benefit for up to the greater of: 30 days per calendar year; or twice the number of days any covered person incurs charges for and was confined to a hospital during a calendar year for the treatment of cancer.

Waiver of Premium

You, the named insured, will not be required to continue to pay premiums to keep your coverage in force if: the first date of diagnosis is while your coverage is in force; and you become disabled, as defined in the certificate, because of cancer after the effective date of your coverage and remain disabled for longer than three continuous months (90 days).

Termination

The policy can be cancelled by the policyholder or us. Your coverage will terminate if the policy terminates, if your premium is not paid, if you are no longer eligible for the coverage or if you ask us to end your coverage. If this is family coverage, coverage on your spouse and dependent children will terminate if the policy terminates, if premium for family coverage is not paid, if your coverage terminates, if you ask us to end their coverage or if you die. In addition, coverage on your spouse will terminate if you divorce your spouse or your marriage is annulled, and coverage on any dependent child will terminate when he no longer qualifies as a dependent child.

Conversion Privilege

If one of the following events occurs:

- your coverage terminates because you are no longer in an eligible class or your class is no longer eligible for coverage, or
- coverage of your spouse under the certificate terminates due to divorce, annulment or your death, or
- coverage of a covered dependent child terminates due to the child becoming married or reaching age 26, or
- coverage of a covered person who has received benefits for the treatment of cancer under the certificate terminates for any reason,

then such covered person may be eligible to obtain an individual policy of insurance (called the converted policy), without evidence of insurability. Obtaining that policy is subject to certain conditions, including but not limited to:

- Such covered person's coverage under the certificate must have been in effect for 12 months unless such covered person has received benefits for the treatment of cancer under the certificate.
- You must be age 64 or younger. Provided, however, that if you have received benefits for the treatment of cancer under the certificate, you may obtain a converted policy even if over age 64.
- Application for the converted policy must be made to us within 31 days after the coverage terminates.
- The converted policy may have different benefits, limitations and exclusions and premium rates.
- If you are eligible for a converted policy, any spouse or dependent children covered under the certificate may also be covered under the converted policy. If a spouse is eligible for a converted policy due to divorce or annulment, any dependent children covered under the certificate may also be covered under the converted policy or they may remain covered under the certificate as you and your former spouse may elect. They may not be covered under both the certificate and the converted policy. If a spouse is eligible for a converted policy due to your death, any dependent children covered under the certificate may also be covered under the converted policy.

Definitions

Cancer

Cancer means a disease which is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells. Pre-malignant conditions, conditions with malignant potential or benign tumors or polyps that do not meet this definition of cancer will not be covered under the certificate. Cancer must be diagnosed by a pathological diagnosis or a clinical diagnosis.

Dependent children

Dependent children means any natural children, step-children, legally adopted children or children placed into your custody for adoption who are: unmarried; chiefly dependent on you or your spouse for support; and younger than age 26.

Internal Cancer
Cancer of an organ other than skin, but including melanoma of Clark's Classification Level III and higher or Breslow .75 or greater.

Pre-existing Condition
Pre-existing Condition means a sickness or physical condition for which any covered person was treated, had medical testing, received medical advice or had taken medication within 12 months before the effective date of the coverage and which is not excluded by name or specific description in the certificate.

Skin Cancer
Skin cancer means: melanoma of Clark's Classification Level I or II (Breslow Classification less than .75mm); basal cell carcinoma; or squamous cell carcinoma of the skin. *Clark's Classifcation* is determined by assessing how many derman (skin) layers the tumor has invaded. The *Breslow Classification* is determined by tumor thickness as measured by a pathologist.

Pre-Existing Condition Limitation: We will not cover cancer that meets the requirements of the Eligibility for Cancer Benefits provision in the certificate but is a preexisting condition as defined in the certificate, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule. No benefits will be payable for any cancer for which the requirements of the Eligibility for Cancer Benefits provision are not met.

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

1200 Colonial Life Boulevard, P. O. Box 1365
Columbia, South Carolina 29202
(800) 325-4368

GROUP SPECIFIED DISEASE INSURANCE

Outline of Coverage

(Applicable to certificate form GCAN-C-CA)

THIS IS LIMITED BENEFIT GROUP SPECIFIED DISEASE COVERAGE. THE POLICY PROVIDES LIMITED BENEFITS FOR CANCER AND CANCER SCREENING PROCEDURES. BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.
If you are eligible for Medicare, review the Guide To Health Insurance for People with Medicare available from the company.

Read your certificate carefully. This outline provides a very brief description of the important features of the Group Specified Disease Insurance certificate. This is not an insurance contract and only the actual policy provisions will control. The policy sets forth in detail the rights and obligations of the policyholder, you and us. The certificate is a summary of the policy and is a written statement, including the certificate schedule, prepared by us to set forth a summary of benefits to which the covered person is entitled, to whom the benefits are payable, and limitations or requirements that may apply and amendments, riders and supplements, if any. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY.

The certificate provides benefits if the first date of diagnosis of cancer or the performance of a cancer screening test occurs: while the certificate is in force; and if the cancer or treatment is not excluded by name or specific description in the policy or certificate. Cancer must be pathologically or clinically diagnosed. If cancer is not diagnosed until after the covered person dies, we will only pay benefits for the treatment of cancer performed during the 45 day period before the covered person's death.

Benefits

$75 Cancer Screening/Wellness Benefit

We will pay this benefit if any covered person has one of the following cancer screening tests performed while his coverage is in force. This benefit is payable once per calendar year for each covered person.

Cancer screening test is defined as:

• Biopsy of skin lesion; • Bone marrow aspiration/biopsy; • Breast ultrasound; • CA 15-3 (blood test for breast cancer); • CA125 (blood test for ovarian cancer); • CEA (blood test for colon cancer); • Chest X-ray; • Colonoscopy;	• Flexible sigmoidoscopy; • Hemoccult stool analysis; • PSA (blood test for prostate cancer); • Serum Protein Electrophoresis (blood test for myeloma); • Thermography; • Virtual Colonoscopy.

Mammogram Benefit $150 per test

We will pay this benefit if a covered person receives a mammogram. The test must be performed:

- while the coverage is in force.

We will pay for one baseline mammogram if the covered person is between the ages of 35 and 39, one mammogram every two calendar years if the covered person is 40 to 49 years of age, or more frequently if recommended by the covered person's physician, and one mammogram each calendar year if the covered person is 50 years of age or older.

Pap Smear Benefit $70 per test

We will pay this benefit if a covered person receives a pap smear or ThinPrep Pap Test. The test must be performed:

- while the coverage is in force.

Hospital Confinement/Hospital Intensive Care Unit Confinement

$200 per day for first 30 days of hospital confinement in a calendar year
$400 per day for hospital confinement after the first 30 days of hospital confinement in a calendar year
$400 per day for hospital intensive care unit confinement
Maximum benefit of 180 days per calendar year for hospital confinement and hospital intensive care unit confinement combined.

We will pay the applicable benefit shown above for each day any covered person incurs charges for hospital confinement or hospital intensive care unit confinement for the treatment of cancer up to the 180-day maximum per calendar year.

Hospital Confinement/Hospital Intensive Care Unit Confinement in a U.S. Government Hospital

$200 per day for first 30 days of hospital confinement in a calendar year
$400 per day for hospital confinement after the first 30 days of hospital confinement in a calendar year
$400 per day for hospital intensive care unit confinement
Maximum benefit of 180 days per calendar year for hospital confinement and hospital intensive care unit confinement combined.

We will pay the applicable benefit shown above for each day any covered person is confined in a U. S. Government hospital or a U. S. Government hospital intensive care unit for the treatment of cancer up to the 180-day maximum per calendar year.

Ambulance **$100 per trip**

We will pay this benefit for each trip any covered person makes if a professional ambulance service transports him to or from a hospital where he is confined as an inpatient for the treatment of cancer. He must incur charges for a professional ambulance service to receive this benefit. We will pay for no more than two one-way trips each time he is confined as an inpatient for the treatment of cancer. We will pay this benefit directly to the provider unless the ambulance bill shows that all charges have been paid in full.

Private Full-Time Nursing **$200 per day**

We will pay this benefit for each day any covered person incurs charges for and uses private full-time nursing services required and authorized by his doctor while he is confined to a hospital for the treatment of cancer. Private full-time nursing must be performed by a registered, a licensed practical or a licensed vocational nurse.

Attending Physician **$50 per day up to a maximum of 180 days per calendar year**

We will pay this benefit if any covered person incurs charges for and uses the services of an attending physician while confined to a hospital for the treatment of cancer. An *attending physician* is a doctor, other than the covered person's surgeon, who performs services for him while confined to a hospital.

Radiation/Chemotherapy **$225 a day up to a maximum of $7,500 per calendar year**

We will pay this benefit for each day any covered person incurs charges for and receives one or more of the following treatments for the purpose of the destruction of malignant cells during the treatment of internal (not skin) cancer up to the calendar year maximum: teleradiotherapy, using either natural or artificially propagated radiation; interstitial or intracavitary application of radium or radioisotopes in sealed or non-sealed sources; or chemical substances that have a cancercidal effect (chemotherapy). Radiation and chemotherapy treatments must be approved for the treatment of cancer by the United States Food and Drug Administration. We will not pay for office visits, laboratory tests, diagnostic X-rays, treatment planning, simulation, treatment devices, dosimetry, radiation physics, teletherapy or other procedures related to these treatments. **This benefit is not payable for skin cancer.**

Antinausea Medication **$50 a day up to a maximum of $200 per calendar year**

We will pay this benefit for each day any covered person incurs charges for and receives antinausea medication administered in a doctor's office, clinic or hospital or has a prescription filled for antinausea medication as a result of radiation or chemotherapy treatments, up to the calendar year maximum. We will pay only one Antinausea Medication benefit per day regardless of the number of antinausea medications the covered person receives on the same day.

Blood, Plasma, Platelets and Immunoglobulins **$225 per day, up to a maximum of $7,500 per calendar year**

We will pay this benefit for each day any covered person incurs charges for and receives a transfusion of blood/plasma/platelets/immunoglobulins during the treatment of cancer, up to the calendar year maximum.

Experimental Treatment **$300 per day up to $10,000 lifetime maximum**

We will pay this benefit for each day that any covered person incurs charges for and receives hospital, medical or surgical care in connection with experimental treatment of internal (not skin) cancer. These treatments must be prescribed by a physician and must be received in an experimental cancer treatment program. Treatment must be received in the United States. **This benefit is not payable for skin cancer.** Payment of this benefit is in place of payment of any other benefit for the same covered treatments.

Hair/External Breast/Voice Box Prosthesis **$200 per calendar year**

We will pay this benefit if any covered person incurs charges for and receives a hair prosthesis, external breast prosthesis or voice box prosthesis needed as a direct result of cancer.

Supportive or Protective Care Drugs and Colony Stimulating Factors **$150 per day up to $1,200 calendar year maximum**

We will pay this benefit for each day that any covered person incurs charges for and receives supportive or protective care drugs and/or colony stimulating factors for the treatment of cancer, up to the calendar year maximum.

Bone Marrow Stem Cell Transplant **$10,000 per lifetime**

We will pay this benefit if any covered person incurs charges for and receives a bone marrow stem cell transplant for the treatment of cancer. We will pay this benefit only once per lifetime for each covered person.

Peripheral Stem Cell Transplant **$5,000 per lifetime**

We will pay this benefit if any covered person incurs charges for and receives a peripheral stem cell transplant for the treatment of cancer. We will pay this benefit only once per lifetime for each covered person.

Transportation **$0.40 per mile up to 700 miles per round trip**

We will pay this benefit if: any covered person travels on his doctor's advice to another city for diagnosis or treatment of his cancer; the destination is more than 50 miles one way from the city where he lives; and he is receiving treatment for internal (not skin) cancer. We will pay this benefit when charges are incurred for travel to and from his destination for either: commercial travel (plane, train or bus); or non-commercial travel (use of a personal car). **This benefit is not payable for skin cancer.**

Transportation for Companion **$0.40 per mile up to 700 miles per round trip**

We will pay this benefit for one companion to accompany any covered person to another city where he is receiving treatment for cancer if: his doctor advises treatment or diagnosis of his cancer in another city; the destination is more than 50 miles one way from the city where he lives; and he is receiving treatment for internal (not skin) cancer.

We will pay this benefit when charges are incurred for travel to and from any covered person's destination for either: commercial travel (plane, train or bus); or non-commercial travel (use of personal car). **This benefit is not payable for skin cancer.**

Lodging **$50 per day up to 70 days maximum per calendar year**

We will pay this benefit for each day any covered person or any adult companion incurs charges for lodging required while the covered person is being treated for cancer more than 50 miles from his residence. We will pay for up to 70 days per calendar year.

Surgery **$60 per surgical unit up to $3,000 per procedure**

We will pay this benefit if any covered person incurs charges for and has a surgical procedure performed by a doctor for treatment of cancer up to the maximum benefit amount.

Anesthesia **25% of the amount of the Surgery benefit paid**

We will pay this benefit if any covered person incurs charges for and receives general anesthesia administered by an anesthesiologist or a Certified Registered Nurse Anesthetist during a surgical procedure that is performed for the treatment of cancer.

$50 per procedure – We will pay this benefit if any covered person incurs charges for and receives local anesthesia during a surgical procedure performed for the treatment of cancer and for which a benefit is payable under this certificate.

Second Medical Opinion **$300 per malignant condition**

We will pay this benefit if any covered person incurs charges for and obtains a second medical opinion from another doctor on recommended surgery or treatment following the positive diagnosis of internal (not skin) cancer. We will pay this benefit only once for each cancerous condition. **This benefit is not payable for skin cancer treatment or reconstructive surgery.**

Reconstructive Surgery **$60 per surgical unit up to a maximum of $3,000 per procedure, including general anesthesia**

We will pay this benefit if a covered person incurs charges for a reconstructive surgery that: requires an incision; is performed by a doctor for treatment of cancer; and is due to internal (not skin) cancer. We will pay for no more than two surgeries per site. **This benefit is not payable for skin cancer.**

If the Reconstructive Surgery benefit is less than the maximum benefit amount allowed for this benefit, then we will also pay up to 25% of the Reconstructive Surgery benefit amount if a covered person incurs charges for and has general anesthesia administered during surgery. For the purposes of this provision, reconstructive surgery includes, but is not limited to, surgical procedures performed following a mastectomy on one breast or both breasts to reestablish symmetry between the two breasts, augmentation mammoplasty, reduction mammoplasty and mastopexy.

Prosthesis/Artificial Limb **$2,000 per device or artificial limb up to a $4,000 lifetime maximum**

We will pay this benefit if any covered person incurs charges for a surgically implanted prosthetic device or artificial limb needed as a direct result of cancer surgery, up to the lifetime maximum. We will pay for no more than one of the same type of device per site.

Outpatient Surgical Center **$500 a day up to a maximum of $1,500 per calendar year**

We will pay this benefit for each day any covered person incurs charges for and has surgery at an outpatient surgical center for internal (not skin) cancer, up to the calendar year maximum. **This benefit is not payable for skin cancer.**

Skilled Nursing Care Facility **$300 per day**

We will pay this benefit for each day any covered person incurs charges for and is confined to a skilled nursing care facility during the treatment of cancer. Confinement must begin within 14 days after the covered person is released from a hospital. We will pay this benefit for no more than the number of days for which we paid the Hospital Confinement/Hospital Intensive Care Unit Confinement benefit or the Hospital Confinement/ Hospital Intensive Care Unit Confinement in a U. S. Government Hospital benefit for his most recent confinement.

Hospice **$300 per day**

We will pay this benefit for each day any covered person incurs charges for and: receives a visit from a representative of a hospice at home; uses the services of a hospital or a U.S. Government Hospital on an outpatient basis under the direction of a hospice; visits a hospice on an outpatient basis for treatment or services as the result of cancer; or is confined to a hospice facility.

Home Health Care Services **$300 per day**

We will pay this benefit for up to the greater of: 30 days per calendar year; or twice the number of days any covered person incurs charges for and was confined to a hospital during a calendar year for the treatment of cancer.

Waiver of Premium

You, the named insured, will not be required to continue to pay premiums to keep your coverage in force if: the first date of diagnosis is while your coverage is in force; and you become disabled, as defined in the certificate, because of cancer after the effective date of your coverage and remain disabled for longer than three continuous months (90 days).

Termination

The policy can be cancelled by the policyholder or us. Your coverage will terminate if the policy terminates, if your premium is not paid, if you are no longer eligible for the coverage or if you ask us to end your coverage. If this is family coverage, coverage on your spouse and dependent children will terminate if the policy terminates, if premium for family coverage is not paid, if your coverage terminates, if you ask us to end their coverage or if you die. In addition, coverage on your spouse will terminate if you divorce your spouse or your marriage is annulled, and coverage on any dependent child will terminate when he no longer qualifies as a dependent child.

Conversion Privilege

If one of the following events occurs:

- your coverage terminates because you are no longer in an eligible class or your class is no longer eligible for coverage, or
- coverage of your spouse under the certificate terminates due to divorce, annulment or your death, or
- coverage of a covered dependent child terminates due to the child becoming married or reaching age 26, or
- coverage of a covered person who has received benefits for the treatment of cancer under the certificate terminates for any reason,

then such covered person may be eligible to obtain an individual policy of insurance (called the converted policy), without evidence of insurability. Obtaining that policy is subject to certain conditions, including but not limited to:

- Such covered person's coverage under the certificate must have been in effect for 12 months unless such covered person has received benefits for the treatment of cancer under the certificate.
- You must be age 64 or younger. Provided, however, that if you have received benefits for the treatment of cancer under the certificate, you may obtain a converted policy even if over age 64.
- Application for the converted policy must be made to us within 31 days after the coverage terminates.
- The converted policy may have different benefits, limitations and exclusions and premium rates.
- If you are eligible for a converted policy, any spouse or dependent children covered under the certificate may also be covered under the converted policy. If a spouse is eligible for a converted policy due to divorce or annulment, any dependent children covered under the certificate may also be covered under the converted policy or they may remain covered under the certificate as you and your former spouse may elect. They may not be covered under both the certificate and the converted policy. If a spouse is eligible for a converted policy due to your death, any dependent children covered under the certificate may also be covered under the converted policy.

Definitions

Cancer

Cancer means a disease which is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells. Pre-malignant conditions, conditions with malignant potential or benign tumors or polyps that do not meet this definition of cancer will not be covered under the certificate. Cancer must be diagnosed by a pathological diagnosis or a clinical diagnosis.

Dependent children

Dependent children means any natural children, step-children, legally adopted children or children placed into your custody for adoption who are: unmarried; chiefly dependent on you or your spouse for support; and younger than age 26.

Internal Cancer
Cancer of an organ other than skin, but including melanoma of Clark's Classification Level III and higher or Breslow .75 or greater.

Pre-existing Condition
Pre-existing Condition means a sickness or physical condition for which any covered person was treated, had medical testing, received medical advice or had taken medication within 12 months before the effective date of the coverage and which is not excluded by name or specific description in the certificate.

Skin Cancer
Skin cancer means: melanoma of Clark's Classification Level I or II (Breslow Classification less than .75mm); basal cell carcinoma; or squamous cell carcinoma of the skin. *Clark's Classifcation* is determined by assessing how many derman (skin) layers the tumor has invaded. The *Breslow Classification* is determined by tumor thickness as measured by a pathologist.

Pre-Existing Condition Limitation: We will not cover cancer that meets the requirements of the Eligibility for Cancer Benefits provision in the certificate but is a preexisting condition as defined in the certificate, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule. No benefits will be payable for any cancer for which the requirements of the Eligibility for Cancer Benefits provision are not met.

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Group Critical Care

$20K

Group Specified Disease Insurance

Colonial Life
Making benefits count.

How will you pay for what your health insurance won't?

It's true—a serious medical event such as cancer, heart attack or stroke could leave you in a period of financial difficulty. Even if you have major medical coverage, there are typically uncovered expenses to consider, such as deductibles and copayments, travel expenses to and from treatment centers and the loss of wages or salary. If faced with this situation, would you be able to maintain your current way of life?

Group Critical Care Insurance may help guard you against financial hardship.

This specified disease coverage from Colonial Life & Accident Insurance Company offers the protection you need to concentrate on what is most important — your treatment, care and recovery.

You're free to use the benefits however you choose. And coverage may be available for you, your spouse/registered domestic partner and your eligible dependents.

Plan Features:

- A lump sum payment allows you the flexibility to better plan your treatment and care.
- You may adjust the face amount to best meet your personal needs.
- May pay multiple times for a covered critical illness.

What benefits are included?

Face Amount: $ 20,000

Critical Illness Benefit: This is a lump sum benefit to assist with the medical and/or non-medical costs associated with the diagnosis of a covered critical illness.

Covered Critical Illness Conditions

For this critical illness…	We will pay this percentage of the face amount:
Heart Attack (Myocardial Infarction)	100%
Stroke	100%
End Stage Renal (Kidney) Failure	100%
Major Organ Failure[1]	100%
Coronary Artery Bypass Graft Surgery/Disease[1]	25%

[1] Benefit for Coronary Artery Disease applicable in lieu of benefit for Coronary Artery Bypass Graft Surgery when Health Savings Account (HSA) compliant plan is selected. Major Organ Failure is not included with the HSA-compliant plan.

Can I use the critical illness coverage more than once?

Yes! This plan includes coverage for subsequent diagnosis of a different critical illness.[2]

If you receive a benefit for a critical illness, and later you are diagnosed with a different critical illness, we will pay the original percentage of the face amount for that particular critical illness.

Yes! This plan includes coverage for subsequent diagnosis of the same critical illness.[2]

If you receive a benefit for a critical illness and later you are diagnosed with the same critical illness (except those listed below), we will pay 25% of the original face amount. *Coronary Artery Bypass Graft Surgery/ Coronary Artery Disease[1] do not qualify.*

[1]Benefit for Coronary Artery Disease applicable in lieu of benefit for Coronary Artery Bypass Graft Surgery when Health Savings Account (HSA) compliant plan is selected. Major Organ Failure is not included with the HSA-compliant plan.

[2]Dates of Diagnoses of a covered critical illness must be separated by at least 180 days.

Mammography Benefit: **$200.**

We will pay this benefit if a covered person receives a mammogram. We will pay for one baseline mammogram if the covered person is between the ages of 35 and 39, one mammogram every two calendar years if ages 40 to 49 or more frequently if recommended by a physician, and one mammogram each calendar year if age 50 or older.

Cervical Cancer Screening Test: **$70.**

We will pay this benefit if a covered person receives a cervical cancer screening test approved by the FDA. This benefit is payable once per calendar year per covered person.

EXCLUSIONS AND LIMITATIONS FOR CRITICAL ILLNESS - We will not pay the Critical Illness Benefit or Benefit Payable Upon Subsequent Diagnosis of Critical Illness that occurs as a result of a covered person's: felonies or illegal occupations; intoxicants and controlled substances; psychiatric or psychological conditions; suicide or injuries which any covered person intentionally does to himself; war or armed conflict; or pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is diagnosed with a critical illness.

This is not an insurance contract and only the actual certificate provisions will control. Applicable to certificate form GCC1.0-CA. Please see your Colonial Life benefits counselor for details.

CA Lic. #_____

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1200 Colonial Life Boulevard
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Group Medical Bridge

Group Specified Disease Insurance

Colonial Life
Making benefits count.

Health Screening Benefit

This benefit helps you pay for part of the expense of tests you may normally have each year. The benefit allows a maximum of 1 screening test per covered person per calendar year.

Tests that qualify:

Stress test on a bicycle or treadmill	CA 125 (blood test for ovarian cancer)
Fasting blood glucose test	CEA (blood test for colon cancer)
Blood test for triglycerides	Chest x-ray
Serum cholesterol test to determine level of HDL and LDL	Colonoscopy
Bone marrow testing	Flexible sigmoidoscopy
Carotid Doppler	Hemoccult stool analysis
Electrocardiogram (EKG, ECG)	PSA (blood test for prostate cancer)
Echocardiogram (ECHO)	Serum protein electrophoresis (blood test for myeloma)
Skin cancer biopsy	Thermography
Breast ultrasound	Virtual colonoscopy
CA 15-3 (blood test for breast cancer)	

For cost and complete details, see your Colonial Life benefits counselor. Applicable to certificate form GCC-1.0-CA. This is not an insurance contract and only the actual certificate provisions will control. The certificate contains exclusions and limitations which may affect benefits payable.

CA Lic. #_____

Group Critical Care 1.0 — Health Screening Benefit – CA

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1200 Colonial Life Boulevard, Columbia, South Carolina 29210
coloniallife.com

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Colonial Life
The benefits of good hard work.®

Group Hospital Confinement Indemnity Insurance

Plan 1

For more information, talk with your benefits counselor.

ColonialLife.com

Group Medical Bridge℠ insurance can help with medical costs associated with a hospital stay that your health insurance may not cover. These benefits are available for you, your spouse and eligible dependent children.

Hospital confinement benefit ..... $ 500 **per day**

Maximum of one day per covered person per calendar year

Health savings account (HSA) compatible

This plan is compatible with HSA guidelines. This plan may also be offered to employees who do not have HSAs.

Colonial Life & Accident Insurance Company's Group Medical Bridge offers an HSA compatible plan in most states.

EXCLUSIONS

We will not pay benefits for losses which are caused by: cosmetic surgery, dental procedures, felonies or illegal occupations, intoxicants or controlled substances, pregnancy of a dependent child, psychiatric or psychological conditions, suicide, intentional injuries, war, armed forces service or giving birth within the first nine months after the certificate effective date. We will not pay benefits for hospital confinement of a newborn child following his or her birth. However, we will pay for a newborn's hospital confinement (following birth) which is the result of a covered sickness or covered accident. We will not pay benefits for loss during the first 12 months after the effective date due to a pre-existing condition, which means a sickness or physical condition for which a covered person was diagnosed or treated within 12 months before the certificate effective date.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to certificate number GMB1.0-C-CA-R. This is not an insurance contract and only the actual certificate provisions will control.

CA LIC#:_____

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The benefits of good hard work.®

Group Hospital Confinement Indemnity Insurance

Health Screening Benefit

For more information, talk with your benefits counselor.

ColonialLife.com

Group Medical Bridge℠ insurance's health screening benefit can help pay for health and wellness tests you have each year.

Health screening benefit ..... **$50 per day**
Maximum of one day per covered person per calendar year

- Any other generally medically accepted cancer screening test not listed
- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Carotid Doppler
- Chest X-ray
- Colonoscopy
- Echocardiogram (ECHO)
- Electrocardiogram (EKG, ECG)
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test for HDL and LDL levels
- Serum protein electrophoresis (blood test for myeloma)
- Skin cancer biopsy
- Stress test on a bicycle or treadmill
- Thermography
- ThinPrep pap test
- Virtual colonoscopy

For cost and complete details, see your Colonial Life benefits counselor. Applicable to certificate number GMB1.0-C-CA-R. This is not an insurance contract and only the actual certificate provisions will control.

CA LIC#:_____

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The benefits of good hard work.®

Group Hospital Confinement Indemnity Insurance

Plan 1

For more information, talk with your benefits counselor.

ColonialLife.com

Group Medical Bridge℠ insurance can help with medical costs associated with a hospital stay that your health insurance may not cover. These benefits are available for you, your spouse and eligible dependent children.

Hospital confinement benefit ..... $ 1000 **per day**

Maximum of one day per covered person per calendar year

Health savings account (HSA) compatible

This plan is compatible with HSA guidelines. This plan may also be offered to employees who do not have HSAs.

Colonial Life & Accident Insurance Company's Group Medical Bridge offers an HSA compatible plan in most states.

EXCLUSIONS

We will not pay benefits for losses which are caused by: cosmetic surgery, dental procedures, felonies or illegal occupations, intoxicants or controlled substances, pregnancy of a dependent child, psychiatric or psychological conditions, suicide, intentional injuries, war, armed forces service or giving birth within the first nine months after the certificate effective date. We will not pay benefits for hospital confinement of a newborn child following his or her birth. However, we will pay for a newborn's hospital confinement (following birth) which is the result of a covered sickness or covered accident. We will not pay benefits for loss during the first 12 months after the effective date due to a pre-existing condition, which means a sickness or physical condition for which a covered person was diagnosed or treated within 12 months before the certificate effective date.

For cost and complete details, see your Colonial Life benefits counselor. Applicable to certificate number GMB1.0-C-CA-R. This is not an insurance contract and only the actual certificate provisions will control.

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The benefits of good hard work.®

Group Hospital Confinement Indemnity Insurance

Health Screening Benefit

For more information, talk with your benefits counselor.

ColonialLife.com

Group Medical Bridge℠ insurance's health screening benefit can help pay for health and wellness tests you have each year.

Health screening benefit ..... **$50 per day**
Maximum of one day per covered person per calendar year

- Any other generally medically accepted cancer screening test not listed
- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Carotid Doppler
- Chest X-ray
- Colonoscopy
- Echocardiogram (ECHO)
- Electrocardiogram (EKG, ECG)
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test for HDL and LDL levels
- Serum protein electrophoresis (blood test for myeloma)
- Skin cancer biopsy
- Stress test on a bicycle or treadmill
- Thermography
- ThinPrep pap test
- Virtual colonoscopy

For cost and complete details, see your Colonial Life benefits counselor. Applicable to certificate number GMB1.0-C-CA-R. This is not an insurance contract and only the actual certificate provisions will control.

CA LIC#:_____

Thank you very much for your continued support!

Please do not hesitate to call us at **1-866-755-6651 (Select Option 1)** or email **CharterLIFE@brmsonline.com .**